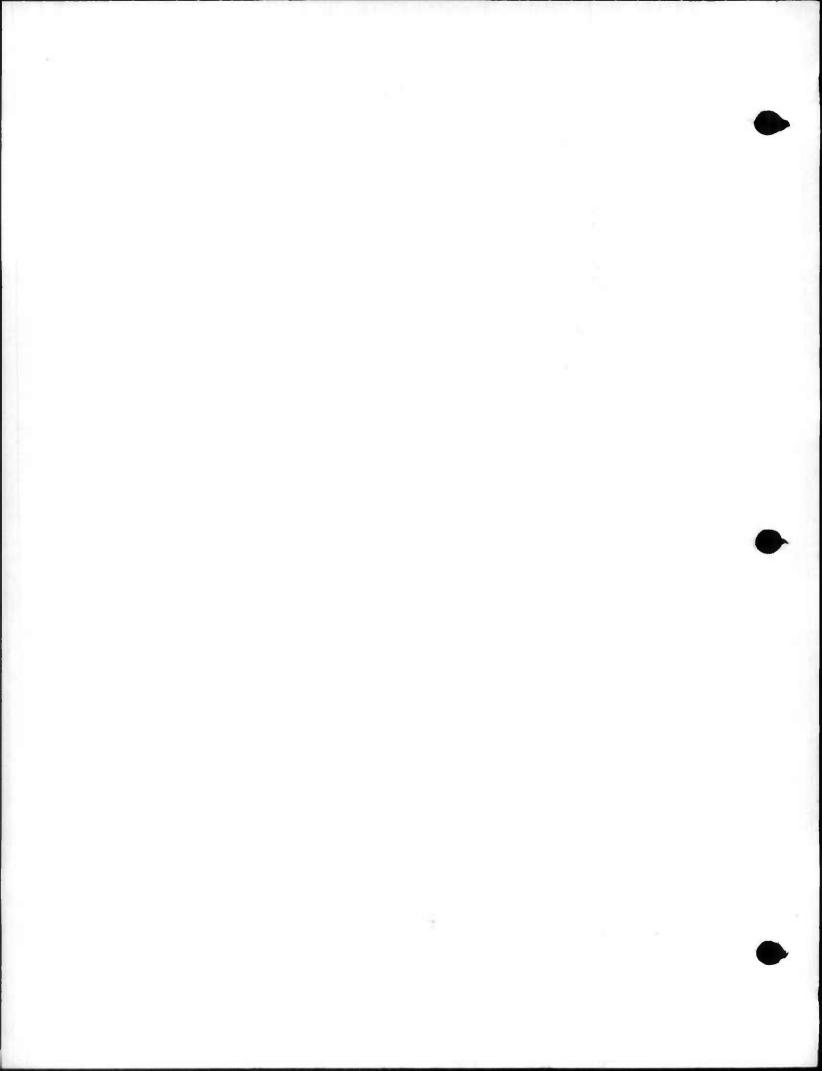
		certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2. 3 should	
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	G PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	hould	
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	NN: T	ficate	Crate
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	NION	R: Aft	filed within 72 hours after death
	ATT	ECTO .	re after
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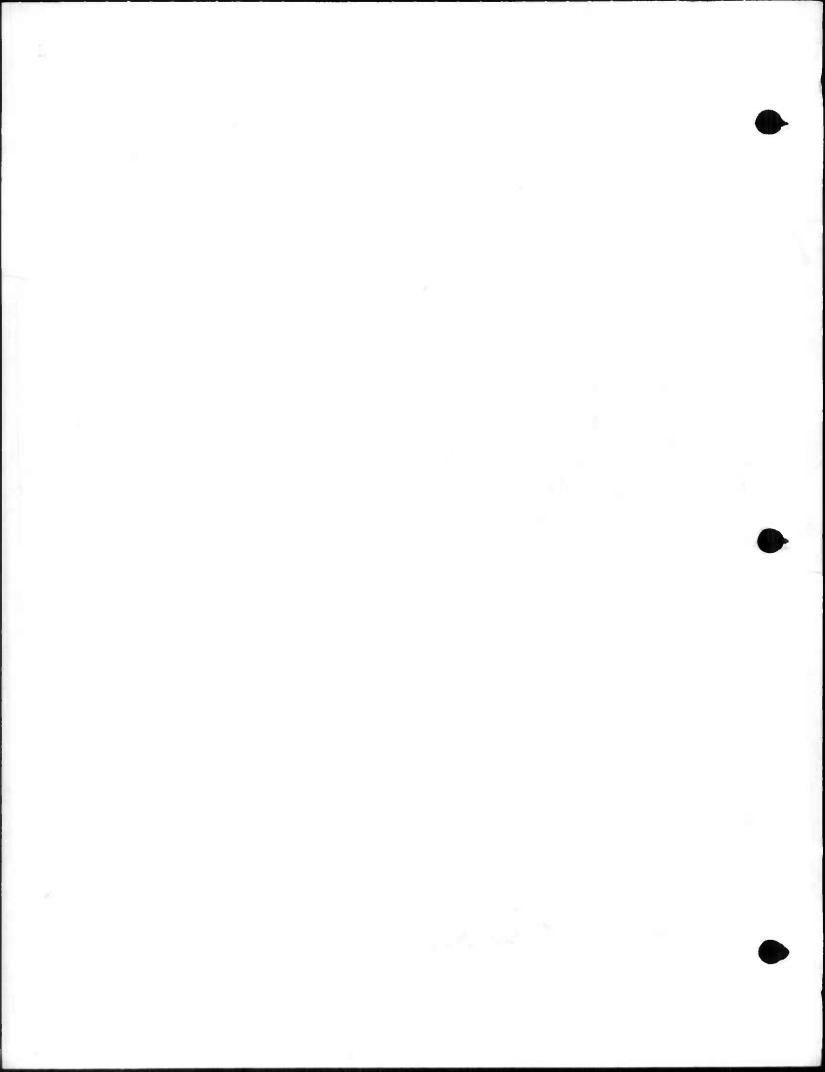
_		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN			
- 1		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			TIME OF OEATH
- 1		Mamie Mary	Rice				March 5,	1995	EAR	7.45 PM
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLAC	CE (State or Foreign
		213-28-4871	1 🗆 M 2 🔀 F	79 ^{YRS.}	ONTHS DAYS	HOURS MIN.	Apr 4, 19		Country) Mar	yland
		Se. FACILITY NAME (If not institution, give s	treet end number)	9	b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY		
	DIRECTOR	2501 Violet Aven	ue		Bal.t	imore			n/a	
	Ä	10a. STATE 10b. COUNT	1	10c. CITY,	TOWN OR LOCA	TION			10d.	INSIDE CITY
	0	Maryland n	/a		Baltim	ore			1 15	LIMITS? TYES 2 NO
	AL	10e. STREET AND NUMBER				. ZIP COOE		10g. CITIZEN	- 41	
	FUNERAL	2501 Violet Aven	ue			21215		II	SA	
	Ş	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS OEC	ENOENT OF HISPAI	NIC ORIGIN? (Specify Ye		RACE A	mericen Indian,
	BY F	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES			2 NO Specific	en, Puerto Ricen, etc.) ly:		Black, Whi Specify:	ite, e1c.
		21				71				Bl.ack
1	ETED	15, OECEDENT'S EDU- (Specify only highest grade	CATION completed)	18e. DECEDENT'S US (Give kind of wor	rk done during mo	ON ast of working	16b. KIND OF BU	SINESS/INDUS		
	E	Elementary/Secondary (0-12)	Coffege (1-4 or 5 +)	We. Do NOT use r						
- 6	COMPL	7th Grade		Domes	stic		Privat		lies	
once.	8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malden	Surneme)		
8	BE	Frank Parran					e Boone			
Ě	2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILINO AI	DDRESS (Street e	and Number or Rural	Route Number, City or Tow	n, State, Zip Co	de)	
90		Sweetie Neormia	Dyson	5519 We	esley A	venue	Baltimore,	Mary1	and	21207
15		20g. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Rem	oval from State 20b	netery, cremetory or other	DISPOSITION (Na	ame of	OATE 20c. LC	CATION — City	or Town, S	itate
Ē		4 Donation 5 Other (Specify)	Wo	oodlawn Ce	emeterv		Mar 9 Bal.	timore	Coun	ty, MD
튙	l l	21. SIGNATURE OF FUNERAL SERVICE LIC			22. NAME A	ND ADDRESS OF FA	CILITY Nutter	Funera	al. Ho	mes, Inc
or removal. medical examiner must be notified at		> pasy of Rolli	no		2501 Balt.	Gwynns i	Falls Park aryland 2	way 1216		
or removal		23. PART i. Enter the diseases, or o	complicatione that cause	d the daeth. Do not	anter the mo	de of dying, suc	h as cardiec or reap	iratory arrest	. 1	Approximete
		shock, or heert fallure. IMMEDIATE CAUSE (Finel	List only one cause on e	ach line.			•		·	Interval Between Onset and Death
f, cremation, event, the	- 1	disease or condition	Renal Fr	1.200						A .
rent,		reculting in death)	e. Renal Fa	CONSEQUENCE OF:						2 years
inal C	2								į	20,0000
Hygiene prior to buria or other traumatic	9	Sequentially list conditions, if sny, leading to immediate	b. hyperten su DUE TO (OR AS A	CONSEQUENCE OF):						regards
pho tra	3	cause. Enter UNDERLYING	- meaterel i	renolarke	my Stem	3503				3 years
the	Ē	CAUSE (Disesse or injury that initiated events		CONSEQUENCE OF):						
Mental Hygiene prior to burial, cremation, ljury, or other traumatic event, the	ERTIFICATION	resulting in deeth) LAST	d							
nd Mental Injury,	O	DADY II Other cloudleant and the								
들	¥	PART ii. Other significent condition	a als as							E AUTOPSY FINDINGS LABLE PRIOR TO
att a	EDIC	Caronary art	cry diseas	, 1501	remic	Cardenny	1 TYES 2	- INO		PLETION OF CAUSE
shows	ME								1 🗆	YES 2 NO
State Dept. of Health Item 23 shows an	IAN:	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIN	NB			
State D	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEATH						
	YSI	1 □ YES 2 □ N6	1 Inpatient 2 ER/Outp		THER: Nursing Hom	e 5 M Residence	8 Other (Specify)			
death with the	PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C		URY AT	28d. DESCRIBE HOW I	NJURY OCCUR	ED	
marked,	β	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 1					
after de 28 Is r	0	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	- A1 home, farm, stre	et, factory, offic	•	281. LOCATION (Street a City or Town, State)		Rural Route I	Number,
n 28	ETE	4 Homicide determined	2.0000000				0.17 0. 10111, 0.0107			
72 hours after If item 28		29e. CERTIFIER (Check only	CIAN: To the best of my know	ledge, death occurred :	at the time, date	end piece, end due	to the cause(e) and me	nner es stated.		
ii 72	OMPL		R: On the besis of exemination						buse(e) end	manner ee stated.
filed within	0	296, SIGNATURE AND TITLE OF CERTIFIER								
	BE	Dringstein mi)			29c. LICENSE NUN		29d. DATE SI		m, Day, Year)
2 €	2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Since O	int	L 13	736	310	8/95	
		1 / 2	n			200				
İ		31. DATE FILED (Month, Days Yang)	1 3 HESCHON COM	Bautmore	- לווא	01205				
		MAR 1 0 1995 8	M. Williams							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.		PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	er this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	narked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AN ATE OF DEATH	D MENTA	AL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, MIDDIO, Last) THOMAS	E. RI	7D, Jr	,	2. DATI	e of DEATH TH DAY	YEAR 3.	TIME OF DEATH 9 55 PM
	4. SOCIAL SECURITY NUMBER 220 - 24-9976 98. FACILITY NAME (If not institution, give str	1 X M 2 🗆 F	66 YRS. MO	UNDER 1 YEAR IF UNDER 24 HF NTHS DAYS HOURS MIN	N. Oct		Virgir	
CTOR	0 11 11	ital	96	Baltimore		9c. COU	A DEAT	
DIRECTOR	Maryland Anne	Arundel		ndale			1.00	d. INSIDE CITY LIMITS? YES 2 X NO
FUNERAL	199. STREET AND NUMBER 1411 Scanon T 11. MARITAL STATUS	Drive		2106	1	Unit	ed S	itates
B⊀	1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, OIVE WAR OR D.	2 NO	13. WAS DECENDENT OF HIS If yes, specify Cuban, Ma 1 — YES 2 NO Sc	SPANIC ORIGI ixican, Puerto pecify:	N? (Specify Yea or No — ! Rican, etc.)	14. RACE — Black, W Specify:	American Indian, Thita, atc.
COMPLETED	15. DECEDENT'S EDUC: (Specify only highest grade of Elementary/Secondary (0-12)		Ille. Do NOT use p	done during most of working tired.)		L KIND OF BUSINESS/INC		
	17. FATHER'S NAME (First, MICOR, Last) Thomas E, Re	eld, Sr.	Fork lit	1 1	NAME (First,	Manu fac	TUIT	ng
TO BE	19a. INFORMANT'S NAME (Type/Print)	own n	196. MAILING AD	DRESS (Street and Number or Ru	ural Route Num	nber, City or Town, State, Zip	- 100	1061
	20a. METHOD OF DISPOSITION 1 Serial 2 Cremation 3 Ramon 4 Constion Tone (Security)	val trom Stata	PLACE AND DATE OF D netery, gremetory or other	ISPOSITION (Name of	31	TE 20c. LOCATION —	City or Town,	sterin Naryland
	ST. SIGNATURE OF PHINENAL SURVICE LICE	ENSEE		2719 Hamm				
	23. PART I. Enter the diseases, or co shock, or heart failure. L IMMEDIATE CAUSE (Final	mplications that caused at only one cause on a	the death. Do not ach line.	antar tha mode of dying,	such as car	diac or reapiratory arr	rest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death) a.	DUE TO (OR AS A	CONSEQUENCE OF):					4 DAYS
ATION	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE OF):	THY				4 YEARS
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):) N				20 YEARS
_	PART II. Other aignificant conditions COROWARY ARE			na undarlying cause given	in Part i.	24s. WAS AN AUTOPSY PERFORMED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE
PHYSICIAN: MEDICA	DID TOBACCO USE CONTR			☑ NO □ UNCERT	AIN 🗆	1 U YES 2 XHO		DEATH?
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)				
PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WORK?		SCRIBE HOW INJURY OCC	CURED	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, term, atree	T TES 2 NO	28f. LOC City	CATION (Street and Number or Town, State)	or Rural Route	Number,
COMPLETED				the time, data and place, and my opinion, death occured at				d manner as stated
TO BE CO	296. SIGNATURE AND TITLE OF CENTIFIES	~ ^	RESIDE	SY 29c. LICENSE 95				righ, Day, Year)
	AHMET HOKE W		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NS BAYVIEND	MED	ICAL CENT	HR, 13	ALTIMORE
	31 MAR 1 0 1995 Jul	32 REGISTRAR'S SIGN						



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and lead to after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

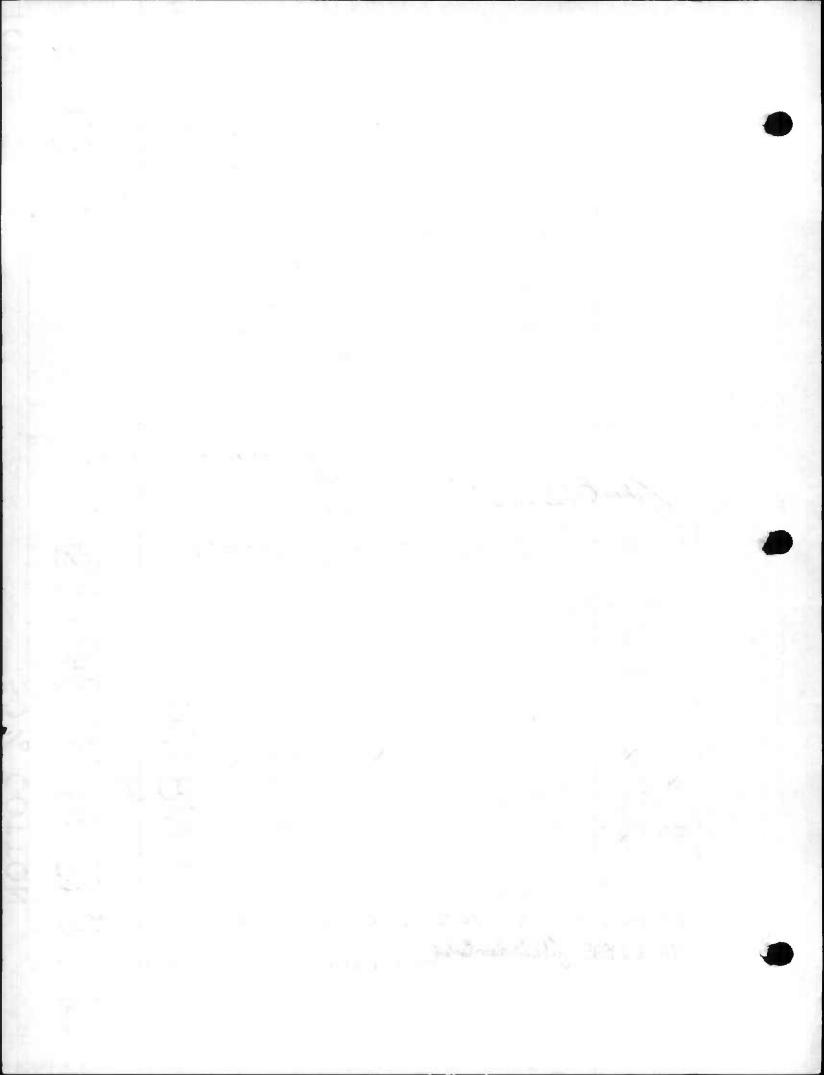
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1	-	FOR STATE REGISTRAF
Г	1. D	ECEDENT'S NA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERTIF	ICATE	OF	DEATH	F	REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)	GEORG	E		RI	411	VEX	2. DATE OF HONTH	27, DAY	95 YE	3, 1	IME OF DEATH
Ì	4. SOCIAL SECURITY NUMBER 219-18-9485	5. SEX 6	AGE (In yrs. 69	iest birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, Di	BIRTH 192	2.5 MZ	RYLA	E (State or Foreign AND
	90. FACILITY NAME (If not institution, give s MANOR CARE RUXTON					NSOI	R LOCATION OF DEA	ATH	9	c. COUNTY (OF DEATH	
ŀ	RESIDENCE OF DECEDENT											
	MARYLAND BAL	rimore			y, town o ALTIN		ION					INSIDE CITY LIMITS? YES 2 NO
	100. STREET AND NUMBER 5017 LEEDS AVENUE	Ξ				101	21227		16	og. CITIZEN	OF WHAT	COUNTRY?
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EX FORCES? 1 X IF YES, GIVE WAY WW	YES 2			f yes, sp	ENDENT OF HISPANI ocity Cuben, Mexicen 2 NO Specify:	, Puerto Rice			Specify	American Indian, ite, etc.
	15. DECEDENT'S EDU	CATION	16a. 1	DECEDENT'S	USUAL O	CCUPATIO	N	16b. KII	ND OF BUSINE	SS/INDUST	RY	
	(Specify only highest grade Elementary/Secondary (0-12) 1.2	Coffege (1-4 or 5+)	- 17	(Give kind of I life. Do NOT u	work done of se retired.) EXECU				SCOU	ring		
ı	17. FATHER'S NAME (First, Middle, Lest)				-		18. MOTHER'S NAM	AE (First, Midd	lle. Meiden Sun	name)	_	
	ROSS			RAINE	Y		MYRA		EΕ		TILT	ON
-	19e. INFORMANT'S NAME (Type/Print)					(Street e	nd Number or Rural R			itate, Zip Cod		
	JANE EMERICK BROW	WN RAINEY					ENUE BALT					
	20e. METHOD OF DISPOSITION 1 🔀 Burtel - 3	oval from State	20b. PLA	CE ANO DAT	E OF OISP	OSITION	(Name	DATE	20c. LOCAT	ION City	or Town,	
	21. SIGNATURE OF PUNERAL SERVICE LIC	JOHN E			22. RU	JCK	D ADDRESS OF FACTOWSON FU	JNERAI	HOME	INC.		
	1/100	elen			10	050	YORK ROAI	TOWS	ON, MI	0. 21:	204	
	shock, or haert feliure. IMMEDIATE CAUSE (Finel disease or condition resulting in dasth)	CAK	RC1.	NO DESCUENCE O	M /	7	of B	RA	IN			Interval Between Onset and Deat
	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. DUE TO (OR	AS A CONS	SEQUENCE O	F):							
	CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OF	AS A CONS	SEQUENCE O	F):							YE II
	PART II. Other aignificant condition	ns contributing to de	ath but no	t resulting	In the ur	nderiyin	g ceuse given in i		e, WAS AN AU PERFORME	D?	AVA	RE AUTOPSY FINDINGS ILABLE PRIDR TO WPLETION OF CAUSE
								_ ¹	YES 2	NO	DF	DEATH?
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			QTHE		ACE OF DEATN (Che	ock only one)				
	1 VES 2 NO 27. MANNER OF OEATN 1 Netural 5 Pending	28e. DATE OF IN. (Month, Day,	JURY	28b. TIA	/4	28c. IN.	URY AT PRINCE YES 2 NO		pecify) IBE NOW INJU	JRY OCCUR	EO	
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF It building, etc	NJURY Al . (Specify)	home, farm,	streel, fact				ON (Street end Town, State)	Number or F	Bural Floute	Number,
	coel -	ICIAN: To the best of my									use(e) en	d manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	lodin					29c, LICENSE NUM	84ª				nth, Day, Yearl
	30. NAME AND ADDRESS OF PERSON WE	O COMPLETED CAUSE	OF OEATH (I	TEM 27) (Type	e, Print) SLE	R	Dr. To.	wso.				
	31. DATE FILED (Month, Day, Year) MAR 1 0 1995	-32 REGISTRAR'S	SIGNATURI									





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DIVISION OF VITAL RECORDS, P.O. BOX	TO THE MOSPITAL OR ATTENDING PHYSICIAN THE law requires that the death certificate be exe	TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician an	10	IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other trauma
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	1 - STATE REGISTRAR	STATE OF MARYLAND				EALTH AN	D MENT	AL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	1					2. DAT	E OF DEATH	AY	YEAR	TIME OF OEATH
		NOSINCES					MA	NCH S	9	5	1030 M
	256-38-9096	5. SEX 6. AGE (In yrs. 1 - M 2 1 F 64	lest birthday) YRS.	MONTHS	DAYS	IF UNDER 24 HR HOURS MIP	N. (Mo	E OF BIRTH	30	Geor	ACE (State or Foreign
FOR	9a. FACILITY NAME (If not Institution, give street University Host			9b. CITY,		ltimo			9c. COUNT	Y OF DEAT	TH .
EG	RESIDENCE OF DECEDENT 10e, STATE 10e, COUNTY		10c. CIT	TY, TOWN OF	PLOCAT	ION				140	d. INSIDE CITY
L DIRECTOR	MB. N/A		Form C.	1, 100111 0.	Ва	1timo	re			1	LIMITS?
FUNERAL	321 N? Stricker	r Street				2122			U	S.	AT COUNTRY?
B	11. MARITAL STATUS 1 A Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 I IF YES, GIVE WAR OR DATES	ARMED	If	yes, spe	ENDENT OF HIS ocity Cuben, Me 2 ANO Sp	exicen, Puerto	IN? (Specify Yes Ricen, etc.)	or No 1	4. RACE — Black, W Specify:	American Indian, white, etc. Black
0	15. DECEDENT'S EDUCA (Specify only highest grade co	ITION 16e.	DECEDENT'S	USUAL OC	CUPATIO	N	16	b. KIND OF BUS	SINESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0-12) 7 th	College (1-4 or 5+)	(Give kind of life. Do NOT us Hous	_		st of working		own H	Home		
BE CON	17. FATHER'S NAME (First, Middle, Last) Unknown						NAME (First,	Middle, Maiden	Surname)		
TO B	190. INFORMANT'S NAME (Type/Print) Tom L. McCoy C	Jr.	196. MAILING	ADDRESS N.	(Street er	nd Number or Ru icker	Stre	mber, City or Town	n, State, Zip C	ode) , MD	. 21223
	20a METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)		CE AND DATE			me of 3/	95	TE 20c, LO			e, MD.
	21. SIGNATURE OF FUNERAL SERVICE LICEN	NSEE		22. N	AME AN	D ADDRESS OF	F FACILITY				
	Doutha 21			81 E	.L.	Phill	ips I	F/H Ba	ilto.	, MB	lonroe St
		mplications that caused tha st only one cause on each l	death. Do i ina.	not anter t	tha mod	da of dying,	such as ca	rdiac or respi	iratory arres	it,	Approximate Interval Batwean Onset and Death
	IMMEDIATE CAUSE (Final disease or condition resulting in dasth)		CAN	DAC		AN	1557				Unset snd Death
Z	b.	DUE TO (OR AS A CONDUCTO OF TO CONDUCTO OR AS A CONDUCTO OR AS A CONDUCTO OR AS A CONDUCTOR OF THE PROPERTY OF	SEQUENCE O	F): NOVA	215	En	دير د				
CERTIFICATION	Sequantially list conditions, if any, laading to immediata cause. Entar UNDERLYING	DUE TO (OR AS A CON	SEQUENCE O	F):							
TIFIC	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE O	F):							
H	d.										
	PART II. Other significant conditions	contributing to death but no	t rasuiting	In the unc	derlying	cause given	in Part I.	24a. WAS AN			ERIE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL								PERFOR		co	MILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
MEC											YES 2 NO
ž	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DI	EATH YE	ES 🗆 N	10 🗆	UNCERT	AIN 🗆				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PL	LACE OF DEA								
YSI	1 YES 2 NO 1	□ Inpatient 2 ER/Outpatient	3 🗆 DOA	4 Nursi		5 🗆 Residen	nce 6 🗆 Oth	er (Specify)			
Ву РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Yeer)	28b. TIM INJ	ME OF S	28c. INJU WOF 1 Y			SCRIBE HOW I	NJURY OCCU	RED	
Person	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, term,	street, factor	ry, office		28f. LO	CATION (Street a y or Town, Stete)	and Number or	Rural Route	e Number,
COMPLE		AN: To the best of my knowledge, On the besis of exemination end/									nd manner es stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE			29d. DATE S	SIGNED (Mo	onth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (TEM 27) (Time	Deient)					710	, Lite	7/12

WAGNEN

32. REGISTRAR'S SIGNATURE

Trons

31. DATE FILED (Month, Day, Year) MAR 1 0 1995

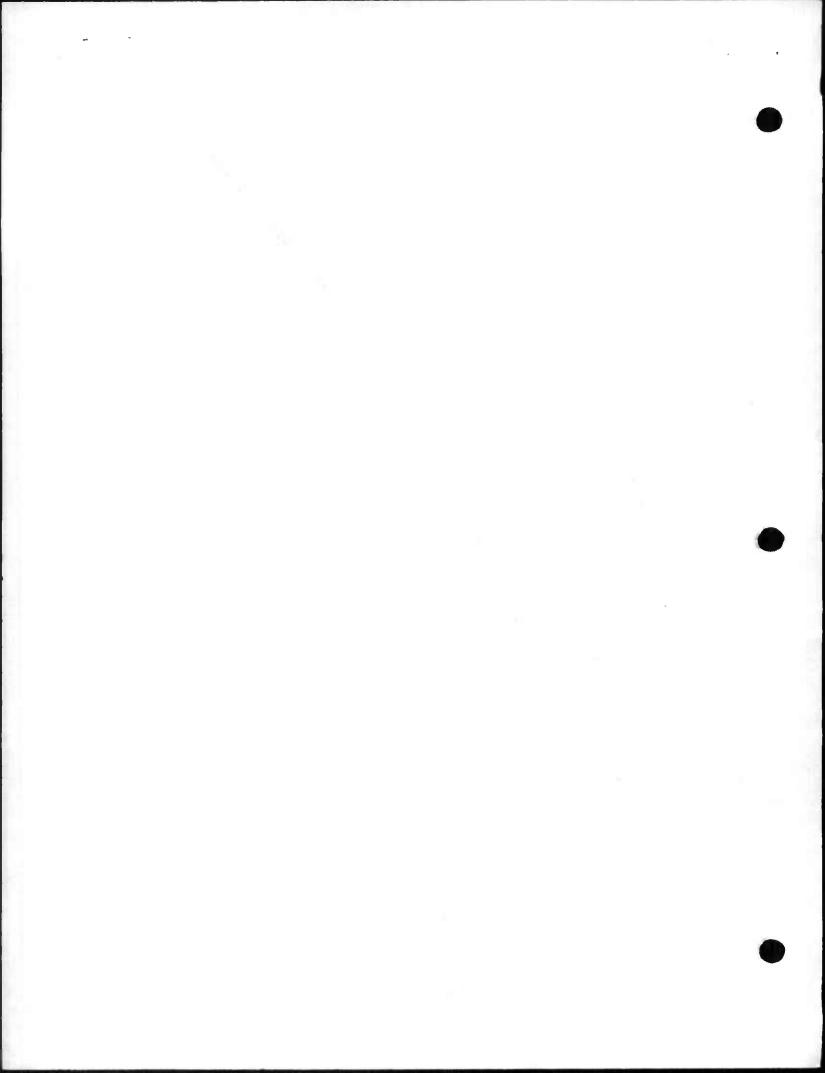
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SICIAN: The law requires that the death certificate be executed within 3-4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	of examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours and the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: It liem as remarked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED IN PAYSICIAN: MEDICAL CERTIFICATION

216-01-6555 1XXM 2 □ F 86 9a. FACILITY NAME (If not institution, give street and number)	Vrs. lest birthday) YRS.	EUNDER 1 YEAR IF UNITHS DAYS HOL	JADER 24 HRS. JRS MIN.	REG. NO. 2. DATE OF DEATH MONTH 7. DATE OF BIRTH		YEAR 3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 216-01-6555 9a. FACILITY NAME (If not institution, give street and number)	yrs. last birthday) IF	F UNDER 1 YEAR IF UNITHS DAYS HOL	INDER 24 HRS. JRS MIN.	2. DATE OF DEATH BOMONTH D	" - 9"	
216-01-6555 1XXM 2 F 86	YRS.	ONTHS DAYS HOL	JRS MIN.	7 DATE OF BIRTH		2 10.2014
	94	CITY TOWAL OR LO	1 1/	(Month, Day, Year) Aug. 19, 190		BIRTHPLACE (State or Foreign Country) Maryland
BESIDENCE OF DECEDENT		Baltimor	CATION OF DEA			Y OF DEATH
10a. STATE 10b. COUNTY		OWN OR LOCATION				10d, INSIDE CITY
Maryland N/A		Baltimore 101. ZIP	CODE			X ✓ YES 2 ☐ NO N OF WHAT COUNTRY?
Bayview Medical Center RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland N/A 10a. STREET AND NUMBER 31 N. East Ave. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U FORCES? 1 YES	J.S. ARMED	13. WAS DECENDE	21224 INT OF HISPANIC	ORIGIN? (Specify Yes		SA I. RACE — American Indian,
3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATE			Cuban, Mexican, NO Specify:	Puarto Rican, etc.)		Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		done during most of wittred.)		18b. KIND OF BUS		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade 17. FATHER'S NAME (First, Middle, Last) Frederick Rouch	Dry Cle			ions – Se] E <i>(First, Middle, Malden</i> eth Kirby	-	loyed
1100 INFORMANT'S NAME (Specifical)	19b. MAILINO AO			ute Number, City or Town		ode)
Lawrence L. Rouch, Jr.	1417 M	t. Airy R	Rd. Bali	timore, Mo	. 212	37
20s. METNOD OF DISPOSITION 1 Surial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify)	20s. METNOD OF DISPOSITION 1 © Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Carried Place) Completely Scrematory of Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Carried Place) Completely Scrematory of Other (Specify)					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	77.5	Lassahn			101 Be	lair Rd. re, Md. 21230
Sequentially list and distance in Hyperte	PACACACONSEQUENCE OF):	enter the mode of	dying, such		atory arrest	t, Approximate interval Between
PART II. Other significant conditions contributing to deeth but Angina Atrial arrhythmic	not resulting in t	he underlying ceu	se given in Pa	24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF			NCERTAIN			1 TYES 2 TO NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 1 Inpetient 2 ER/Outpetient 2 ER/Outpetient 2 ER/Outpetient 1 Inpetient 2 ER/Outpetient 2 ER/Outpetient 2 ER/Outpetient 3 ER/Outpetient		Check only one) THER: Nursing Nome 5	Residence 8	Other (Specify)		
27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28b. TIME OF	F 28c, INJURY A	T 2	8d. DESCRIBE HOW IN	JURY OCCUR	IED
3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — building, atc. (Specify)	At home, term, stree	it, factory, offics	2	8t. LOCATION (Street a: City or Town, State)	nd Number or i	Rural Route Number,
29a. CERTIFIER (Check only 1 CERTIFYINO PNYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the basis of examination as SIGNATURE AND TIPE OF CERTIFIES	nd/or investigation, in	n my opinion, death o		ne, data and place, and	dus to the c	ause(a) and manner as stated.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

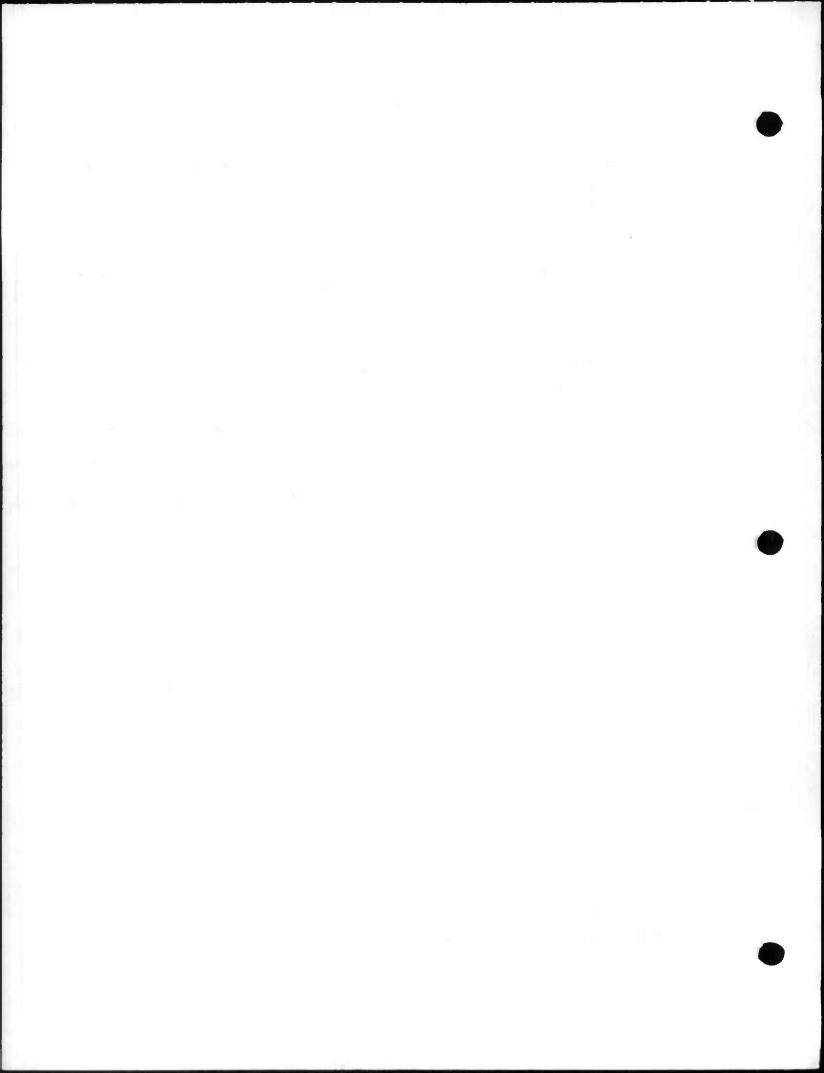
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR				CATE OF	DEATH	REG	NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEAT	Ή		3. TIME OF DEAT	ГН
	Ernest	Δ		D	obinso	n	MONTH M = 300	DAY	995	1000	75 M
		5. SEX	6. AGE (In yrs. las		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Mar 7. DATE OF BIRT	7.7		HPLACE (State or Fo	AM
	234 20 0200	1 🖳 M 2 🗆 F	~ ~		IONTHS DAYS	HOURS MIN.	(Month, Day, Ye	nr)	Count	iry)	reign
			53				03-10-	42		Md.	
_	9a. FACILITY NAME (If not institution, give stre	et and number)		- 9	Ib. CITY, TOWN O	R LOCATION OF D	EATH	9c. COL	INTY OF	PEATH	
Ö	401 E. 25th Stre	eet-Apt	. 4B	1	Balti	more			N/	4	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY										
DIRECTOR		M/A		10c. CITY,	TOWN OR LOCAT	ION				10d. INSIDE CITY LIMITS?	
	Md.	11/4		Ba	ltimor	ce				1 -YES 2 -	NO
₹	10s. STREET AND NUMBER				101.	ZIP CODE		10g. CIT	IZEN OF	WHAT COUNTRY?	
55	401 E 25th St.					27270			Т	TT C	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	WED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specif	y Yes or No-	14. RAC	E — American India	en.
	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA		0	II yes, spe	2 NO Specific	in, Puerto Rican, ato	.)	Blac	k, White, atc.	,
ВҰ	3 🖾 Widowed 4 🗍 Divorced					A decay	,		Spec	Black	
	15. DECEDENT'S EDUCA	TION			SUAL OCCUPATIO		16b. KIND O	BUSINESS/IN	DUSTRY		
ᇤ	(Specify only highest grade co	College (1-4 or 5+)	life	Do NOT use i	rk done during mos retired.)	st of working					
립	12			14 k 2	nown		lun	Knou	170		- 1
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			0(1)	700	18 MOTHER'S NA	ME (First, Middle, Me				_
	Francet Debine										
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임	the state of the s										
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	20er METHOD OF DISPOSITION 1 Derial 2 Cremation 3 Remov	al from Stala									
	4 Donation 5 Other (Specify)		Ceda	rHi	11 Cem	etery 2	2/74/05 ciuty	Balt	0. 1	. DIV	
- 1	21. SIGNATURE OF FUNERAL SERVICE LICE	VSEE	,		22. NAME AN	D ADDRESS OF FA	CILITY				
	12 - 20 111	10.	Died!	1	Wain	wright	Funera	l Hom	е		- 1
	23. PART i. Enter the diseases, or co	The state of the	0000	7	12700	Edmon	dson Av	e Ba	1to		
	shock, or heart failure. Li	at only one ceus	e on each line.	ith. Do not	enter the mod	de of dying, suc	h aa cerdiac or r	eapiratory ar	reat,	Approximation interval Be	
	IMMEDIATE CAUSE (Final	1		0	45 /	Pa		0.			
	disease or condition resulting in death)	Aprile	wisc	le à	1-1	and the	or cula	Un	(m	0	
		DUE TO (OR AS A CONSEC	UENCE OF):	~			001			
z											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (C	R AS A CONSEO	UENCE OF):						-	
\ <u>\text{8}</u>	cause. Enter UNDERLYING										- 1
Ē	CAUSE (Diseese or Injury that initiated events	DUE TO (C	R AS A CONSEC	UENCE OF):						+	
듄	resulting in death) LAST										- 1
											- 1
2	d.										
	PART II. Other significent conditions	contributing to d	eath but not re	suiting In	the underlying	cause given in	Part I. 24a. WA	S AN AUTOPSY	24b	. WERE AUTOPSY FI	
	PART II. Other significent conditions	contributing to d	eath but not re	sulting in	the underlying	cause given in	PE	FORMED?	24b	AVAILABLE PRIOR COMPLETION OF C	ro
EDICAL	PART II. Other significent conditions	contributing to d	eath but not re	sulting in	the underlying	cause given in	PE		24b	AMAILABLE PRIOR COMPLETION OF	AUSE
MEDICAL							1 - YE	FORMED?	246	AVAILABLE PRIOR COMPLETION OF C	AUSE
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BALTIMORE, MARYLAND 21215-0020 Rt death. Page 6 may be retained by the hoscital or stranding objection

DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. DATE FILED (Month, Day, Year)
MAR 1 0 1995

HYSICIAN: The law requires that the death certificate be executed within 24 hours after of
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be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR STEPHEN ROWAN MARCH 06 1994 09:53 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5.JSEX 7. DATE OF BIRTH (Month, Day, Year) 2 - 19 - 23 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS DAYS 72 1 X M 2 - F YRS. 218 12 5535 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Memorial Hospital CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Allegany XX YES 2 NO Cumberland FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 21502 212 Decatur St USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yee, specify Cuban, Maxicen, Puerto Ri

1 YES 2 NO Specify: 1 Never Married 2 X Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during m life. Do NOT use retired.) Machinist Elementery/Secondary (0-12) College (1-4 or 5+) Railroad/Chessie 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stephen E. Rowan. Nora Martin BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 J. GreenSt, Cumberland, A. Rowan MD 21502 Mrs 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 □xDonation 5 □ Other (Specify) unk unknown unknown IL SIGNATURE OF FUNERAL SERVICE LICENSEE ROnald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.Baltimore St.Balto, MD21201 mari 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only one causa on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition Diabetes Mellitus 10 Years resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Prostate Cancer CERTIFICATION One Year Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST Coronary Artery Disease One Year PART II. Other algolificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: N/A 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 ☐ YES 2 ☐ NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge Assett on curred at the time, date and place, and due to the cause(a) and manner ea stated. 2 MEDICAL EXAMINER: On the basis or investigation, in my opinion, death occured at the time, data and placa, end due to the cause(a) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE In Manda 7, 1997 D36766 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTER'S SIGNATURE DERICK ST CUMBER LAND

in Muchen Randall

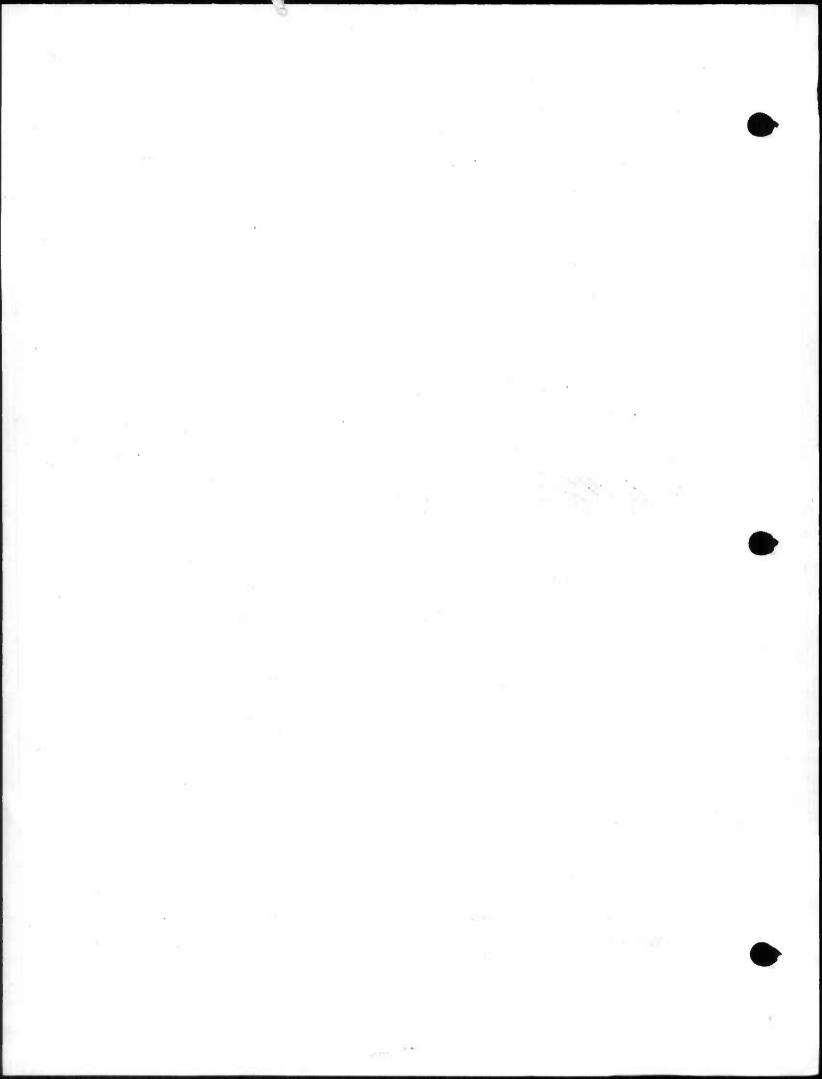
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmit page 1.9.3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.
IMPORTANT: Il Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND) / DEPAR	TMENT OF H	EALTH AND DEATH	MENTAL	HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last) Margaret St 4. SOCIAL SECURITY NUMBER	S. SEX 8. AGE (In yrs.	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	MONTH Marc	of BIRTH	1995	3. TIME DF DEATN G. 30 A M BIRTHPLACE (State or Foreign
	94. FACILITY NAME (If not institution, give stree	1 M 2 00 F 8	8 YRS.	MONTHS DAYS	HOURS MIN.	Sept.	, Day, Year)	906 N	lary land
CTOR	5612 Braxfield	Road		Arbut		PEATN		Balt	IMORE
- DIRECTOR	Maryland Balti	more		town or Locat	>				10d. INSIDE CITY LIMITS? 1 YES 2 ND
FUNERAL	5612 Braxfiel	d Road		101	21227	7		Unite	of WHAT COUNTRY?
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 N Divorced	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED		ENDENT OF HISPA relity Cuben, Mexico 2 NO Specia	an, Puerto R		or No- 14.	RACE — American Indian, Black, White, etc. Specify:
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	mpleted)	DECEDENT'S (Give kind of w life. Do NOT use		ON st of working	16b.		Home	
	John Sconfield	4			18. MOTHER'S NA		liddle, Maiden		nKnown
TO BE	190. INFORMANT'S NAME (Typo/Print) Helcine E. Broo		196. MAJLING 5612		nd Number or Aural Field Ro	Route Numb		n, State, Zip Coo	
	20a. METNOD OF DISPOSITION 1 Description 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	20b. PLAC	CEAND DATEO	F DISPOSITION (Na	me of	OATE	20c. LO	CATION - CITY	or Town, State
ŀ	21. SIGNATURE OF FUNERAL SERVICE HOEN) n		netery D AODRESS OF FA	ICILITY A	nbrose	Funero	d Home, Inc.
ď	The state of		4	13285	Sulphur S	pring	Rd., A	rbutu	5, MD 2/227
1	IMMEDIATE CAUSE (Final disease or condition	t only one cause on each I	ine.		e of dying, such				Approximate interval Between Onset and Death
N	Sequentially list conditions,	DUE TO (OR AS A CONS	SEDUENCE OF	re H	earl	7	ril u	re	5m
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONS	SEQUENCE OF	brok	lativ	2			3 yrs.
SERTI	resulting in death) LAST								
MEDICAL	PART II. Other algorificant conditions of the co	contributing to death but no	et resulting li	the underlying	cause given in		24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
N N	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF DE	EATH YES	0 NO 🗆	UNCERTAI	N D			1 TES 2 NO
PHYSICIAN:		IOSPITAL:		(Check only one)					
HYS	1 YES 2 NO 1	□ Inpatient 2 □ ER/Outpatient 28s. DATE OF INJURY		4 - Nursing Home	Residence	1		JURY OCCUR	50
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1 TY	RK? ES 2 ND	200.020	June How II	JOHN OCCOM	
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, farm, st	reet, factory, office		281. LOCA City or	TION (Street a r Town, State)	nd Number or F	tural Route Number,
COMPLETED		N: To the best of my knowledge, On the basis of exemination end/o							use(a) and menner as stated.
H	29b. SIGNATURE AND TITLE DF CERTIFIER	26.		46	29c. LICENSE NUI	MBER	,	29d. DATE SIG	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	an.	TEM 27) (Type, 1		05 Eas	1 6 C	Drie	, 1	10 70
	MAR 1 0 1995	32. REGISTRAR'S SIGNATURE		080	200	J. 74	-1100	_ /7/	purus / M

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			1 - STATE REGISTRAR		STATE OF	MARYL					DEAT		MENTA	REG. NO.	_		
			1. DECEDENT'S NAME (First, Mide	dle, Last)						_			2. DATE	OF DEATN	AY	YEAR 3.	TIME OF DEATH
			Henry 4. SOCIAL SECURITY NUMBER		arl St		zer		T -				3	9		95	12.30P M
			219-26-24		5. SEX		(In yrs. last b		IF UNDER	DAYS	IF UNDER	MIN.	(Mont	OF BIRTN h, Day, Year)	20	Country)	ACE (State or Foreign
	Dino		90. FACILITY NAME (If not instituti				00 16	ars		, TOWH C	OR LOCATION	ON OF DE		9-17-	_	PA., U	
	n o	OR	1301 Edgewo		oad					Edge	ewood	1				Harfor	'd
	rages I,	ЕСТО	HESIDENCE OF DECED	L COUNTY			1	10c. CIT	Y, TOWN	OR LOCAT	ION						Id, INSIDE CITY
å	- L	DIR	MD	На	rford					gew							LIMITS?
	Ē	ERAL	10e. STREET AND NUMBER								. ZIP CODI				10g. CIT		T COUNTRY?
- 1	T SELECT	NEH	1301 Edg			and the same of th						1040			<u> </u>	US	A
020 physician.	100	FUN	11. MARITAL STATUS t Never Merried 2 The Marr	ried	FORCES?	I 🗌 YES	2 00	D		It yes, spi	ecify Cube	n, Mexicer	n, Puerto	l? (Specify Yea Rican, atc.)	or No-	Black, W	American Indian, thits, atc.
		ВУ	3 Widowed 4 Divorced		IF YES, GIVE	MAR OR D	AIES			1 U YES	2 NO	Specify				Specify	hite
ND 21215-0 hospital or attending	000	ETED	15. DECEDEN (Specify only high				18e. DECE (Give	kind of	work done	CCUPATIO	ON st of workin	ng	16b	. KIND OF BUS	SINESS/IN		
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AND the hospit	mce.	COMPL	17. FATHER'S NAME (First, Middle,	Last)								VER'S NAI	ME (First, i	Middle, Melden			
3 3	8 75	ш	Arthur S	weitz	er						A	nna	Sn	nith			
E igi Z		TO B	19e. INFORMANT'S NAME (Type/P		/	<i>c</i>)								ber, City or Town			
E, N	2		Gisela I. Sw	eitze	er (Wi	fe)		-				l., E		700d, N			
6 mg			t Buriel 2 Cremetion 3 4 Donetion 5 Nother (Spec	effy) Ent	el trom State	20b	D. PLACE AND THE PLACE AND THE PLACE AND THE	tory or o	ther place)	sition/Na Lith	Maus		3/1			City or Town,	aryland
death. Page 6 m			21. SIGNATURE OF FUNERAL SET						22.	NAME AN	D ADDRE	SS OF FAC	CILITY				aryrand
after death. Page 6 may be			11/11/19	1911	/									. Homes Baltin			1226
urs after of	E S		23. PART I. Enter the disease shock, or heert	ses, or co	mplications the	t cause	d the death	h. Do r	not enter	the mo	de of dy	ng, such	as care	lac or reapl	ratory ar	rest,	Approximata
Silod in h	rial, cremation, or c event, the me		IMMEDIATE CAUSE (Finel disease or condition	Tuller C. E.	or only one co	DOC DIT C	recir inte.										Onset and Death
D in the control of	d, cremati event, t		resulting In death)	a.	Acut	e C	Oron	ary	Ar	ter	y Di	lsea	se				
executed with	ic ev	_			ASC		001132001	.140.									1
	rior to buria	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate				CONSEQUE	ENCE O	F):								
death certificate be	9 5	-ICA	Cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated evente C. Hypertension Due to (OR AS A CONSEQUENCE OF):														
leath certification	Hygiene or other	E	that initiated evente reaulting in deeth) LAST	١.		(on no n	001102000		. ,.								
death death	injury, o	O	PART II. Other elgoificent or	onditions.	anntelbuting to	dooth b			In the same	-111							
Y = 2	E -	CAL	PART II. Other algnificant co	OHOITIOHS			s Me				g cause (jiven in i	Part I.	24a. WAS AN PERFOR		AV	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE
quires t	S de	MED			Dia	,	.0_110	<u> </u>	LLUS				_	t YES 2	□ X o	OF	DEATH?
Y P	sh of	ä														1 "	YES 2 NO
A Per se		PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER?		HOSPITAL:				OTHE		ACE OF D	EATH (Che	ck only or	e)			
SICIAN: TE	or if	IXSI	1 XYES 2 NO 27. MANNER OF DEATN		28s. DATE OF			DOA	4 🗌 Nur		o 5 □ Re	eldence					
D ₹ ₹	With Will		1 Netural 5 Pend		(Month, E		'		IURY	t V	RK7	ON	28d. DES	CRIBE NOW II		CURED	
MDING C	death Is ma	D BY	2 Accident Invest 3 Suicide 8 Could	tigation d not ba	28e. PLACE (OF INJURY	f — At home						28t. LOC	ATION (Street a		r or Rural Rout	e Number,
S A	2 2			mined	- Sunding	ate. (oper	N.	A					City	or Town, State)	A		_
5 (5 8	100	급			AN: To the beet o												
200	4	COM	one) 2 X MEDICAL	EXAMINER:	On the basis of e	xaminatio	n and/or invi	eatigatio	on, In my o	pinion, de	eath occur	ed at the	time, date	end place, en	d due to t	he cause(e) er	nd manner se stated.
10 THE H	be filed	BE (29b. SIGNATURE AND TITLE OF	CERTIFIER	1/1-			- (29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED (M	onth, Day, Year)
2 5	IM pe	5	30. NAME AND ADDRESS OF PER	SON WHO	COMPLETED CALL		S. P			M.D	. D	218	09			3-9-9	5
			G.S. Prabh							# 1 ·	02 T	1.11	a + -	a MD	2104	7 / 7	0 0 7 0 7 5
	1		31. DATE FILED (Month, Day, Year)	5 jil	32,00000	De Pa	Mari	1.	ВЛ	II I	UZ F	all	SEO	ı MD.	2102	1 41	0-879-656
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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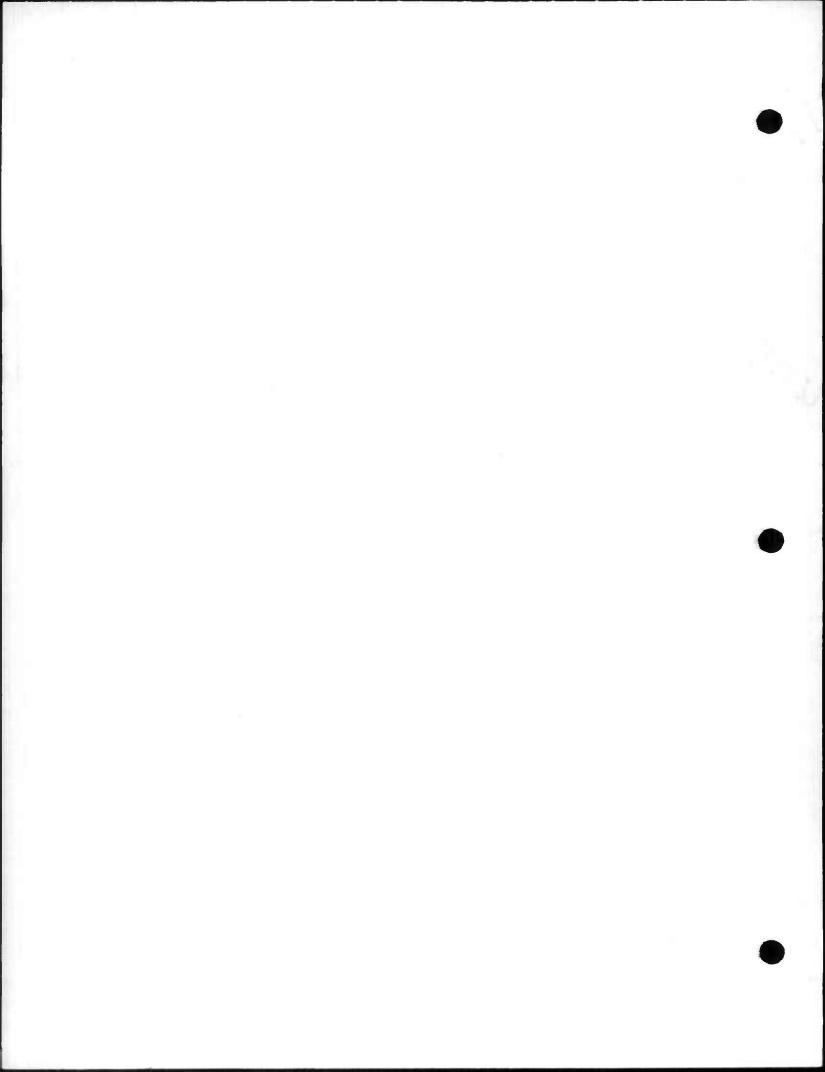
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	1 - STATE REGISTRAR	STATE OF MA					IEALTH DEAT		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)								2. DATE OF OEATH			3. TIME OF OE	ATH
	MARIA AN	IN			S	INES			MARCH O	6	95AR	8:35	P.M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest	birthday)		R t YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		6. BIRTH	PLACE (State or	Foreign
	217-40-3391	I M 2 M F S	51	YRS.	MONTHS	DAYS	HOURS	MIN.	March 2,	1944	Country	yland	
	9a. FACILITY NAME (If not institution, give stree	et and number)			9b. CIT	Y, TOWN E	OR LOCATIO	ON OF DE		_	INTY OF DI	-	
H.	1045 RODMAN WAY				,	יתי ז עכו	TMODE	OTI	TNI	N	I/A		
ਨ	RESIDENCE OF DECEDENT					DALI.	LMORE	i CI.	IY		7/11		
DIRECTOR	10a. STATE 10b. CDUNTY					OR LOCAT						10d. INSIDE CIT	ΓY
	Maryland N/A			Bal	tim	ore (City					1 X YES 2	NO
Z Z	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?	
FUNERAL	1045 Rodman Way					1 2	21205				U.S.	Α.	
5		2. WAS DECEOENT ET			13.	WAS DEC	ENOENT D	F HISPAN	IC ORIGIN? (Specify Yes	or No-	14. RACE	— American Inc., White, etc.	dlen,
BY I	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR		•			2 NO		n, Puerio Rican, etc.)		Special Whil		
		The state of the s									Whi	te	
TE	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION mplated)	(Giv	re kind of v	vork done	during mo	ON st of working	g	16b. KIND OF BUS	SINESS/INI	DUSTRY		
٦	Elementary/Secondary (0-12) 12th Grade	College (1-4 or 5+)		Do NOT us	,				m-11				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Pay	roll	. CIE	erk			Telepho		compa	ny	
S		- Fi - 1 A							ME (First, Middle, Maiden				
BE	Samuel Anthony Sch	orrera					Jul		Unknown		mmin	gton	
2	Michael Anthony Si	200							Soute Number, City or Town			23.205	
	20a. METHOD DE DISPOSITION	nes						, Ba	altimore, M				
	1 Buriel 2 Cremetion 3 Remove 4 Donetion 5 X Other (Specify)	from State	20b. PLACE AI	ND DATE (oF OISPO:	SITION /Na	me of	2			City or Tox		, 1
	21. SIGNATURE OF FUNERAL SERVICE LICEN		HOTTA	HIII		-			/11/95 Bal	Ltimo	ore,	Marylar	na
	21. SIGNATURE OF PURERAL SERVICE LICEN	SEE	,	/	JC	ohn (D ADDRES	ller	Inc.				
	Kathleen	m. M.	ink	1					oad, Baltir	more.	Mar	vland 2	21206
	23. PART I. Enter the disessee, or con	nplicatione that ca	used the dea	ith. Do n	ot ente	r the mo	de of dyle	ng, sucl	h se cerdiec or respi	ratory an	reet,	Approxir	
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CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (DR	AS A CONSEQU	UENCE OF	7:								
S	CAUSE (Disease or injury												- 1
E	thet initiated events	DUE TO (DR	AS A CONSEDE	UENCE OF):								
EH	resulting in death) LAST												
_	PART II. Other eignificent conditions of	ontributing to dea	eth but not re-	sulting I	n the III	nderlylog	CAURA O	luen in I	Part I. 24s, WAS AN	ALIZONOV	200		-10-100-1-10
CA	Diabetes me			outing i	ii die oi	i i dia i i y ii i g	causa 9	14611 111	PERFOR		-	WERE AUTOPSY AVAILABLE PRIDI	OT F
	Chronic al								1 XYES 2	□ NO		OF DEATH?	
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A	DID TOBACCO USE CONTRIB	BUIE IO CAUS		_			UNC	RTAIN	1 1 .				
PHYSICIAN: MEDICAL		IOSPITAL:	28, PLACE	I	OTHE!								
ΥS		☐ Inpetient 2 ☐ ER			4 🗆 Nur	rsing Home	777	Idenca	6 Other (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Y		28b, TIME		28c. INJ	RIC?		28d. DEŞCRIBE HOW II	NJURY OC	CURED		
В	2 Accident Investigation				M		ES 2 🗌	ND					
유	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF IN- building, atc.	JURY — At hom (Specify)	ie, ferm, a	treet, fac	tory, office	ı		28f. LOCATION (Street a City or Town, State)	nd Number	or Rural Ad	oute Number,	
) seminor	<u> </u>											
필									to the cause(a) and man				
COMPLETED	2 MEDICAL EXAMINER: C	On the basis of exami	nation and/or im	vestigation	n, in my o	opinion, de	eth occure	d at the t	time, date and place, en	d due to th	e ceuse(a)	and manner as	stated.
BE 0	29b. SIGNATURE AND TITLE OF CENTIFIER	0 110	1 2				29c. LICE	NSE NUM	BER	29d, DAT	E SIGNED	(Month, Day, Year,	, -
	Denni	Q. Ch	uti ni	1			0.C	M.E		▶ M	ARCH	7,1995	
임	30. NAME AND ADDRESS OF PERSON WHO A	Zum even autor n				_			-	1.1	TIVIT	111222	

PENN STREET BALTIMORE MARYLAND 21201



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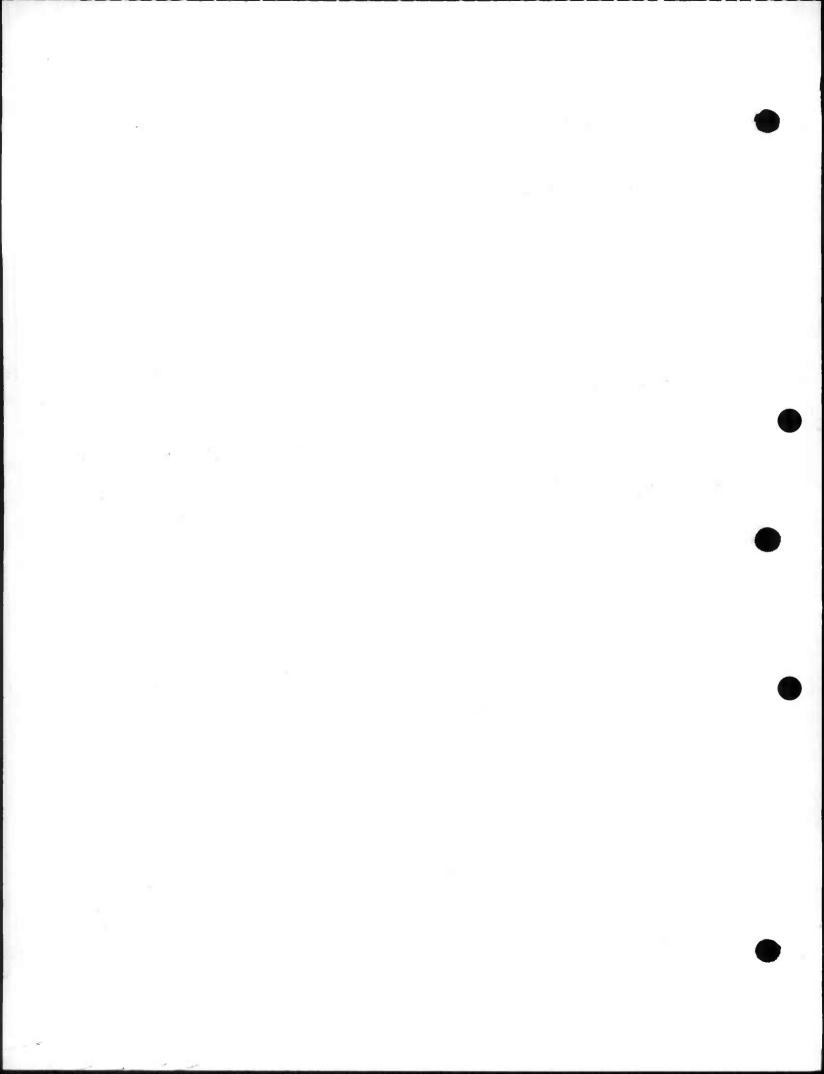
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPLETED BY FUNERAL DIRECTOR

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S STENATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH STOLZENBACH CATHERINE 1995 740 M MAR 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH DAYS HOURS 1 🗌 M 2 🔀 F 220-46-9890 76 YRS. 9,1918 Virginia 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH North West Hospital Center Randallstown Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland N/A Baltimore 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21229 409 Westgate Road U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Norried It yee, specify Cuben, Mexicen, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES Specify: 1 TES 2 NO Specify: 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Health Care 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) Yates Winstead Alma Maith 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stolzenbach (Spouse) 409 Westgate Road Baltimore Maryland 21229 20e. METHOD OF DISPOSITION

TV Burlel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Woodlawn Cemetery March 11, 1995 Woodlawn, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes Jusqueon 1630 Edmondson Avenue Catonsville Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line Interval Batwean IMMEDIATE CAUSE (Final Onset and Death SEPSIS = DEHYDRATION disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): HYPEROSMOLAR STATE Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS PIDRIUATION - YES 2 DONO AVAILABLE PRIOR TO AODM. ATRIAL COMPLETION OF CAUSE 1 - YES 2 100 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 YES 2 AO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 4 Homicide determined 29e. CERTIFIER 1 DECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner ee steted. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) MAR 8, 1995



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LED BY PHYSICIAN: MEDICAL CERTIFICATION

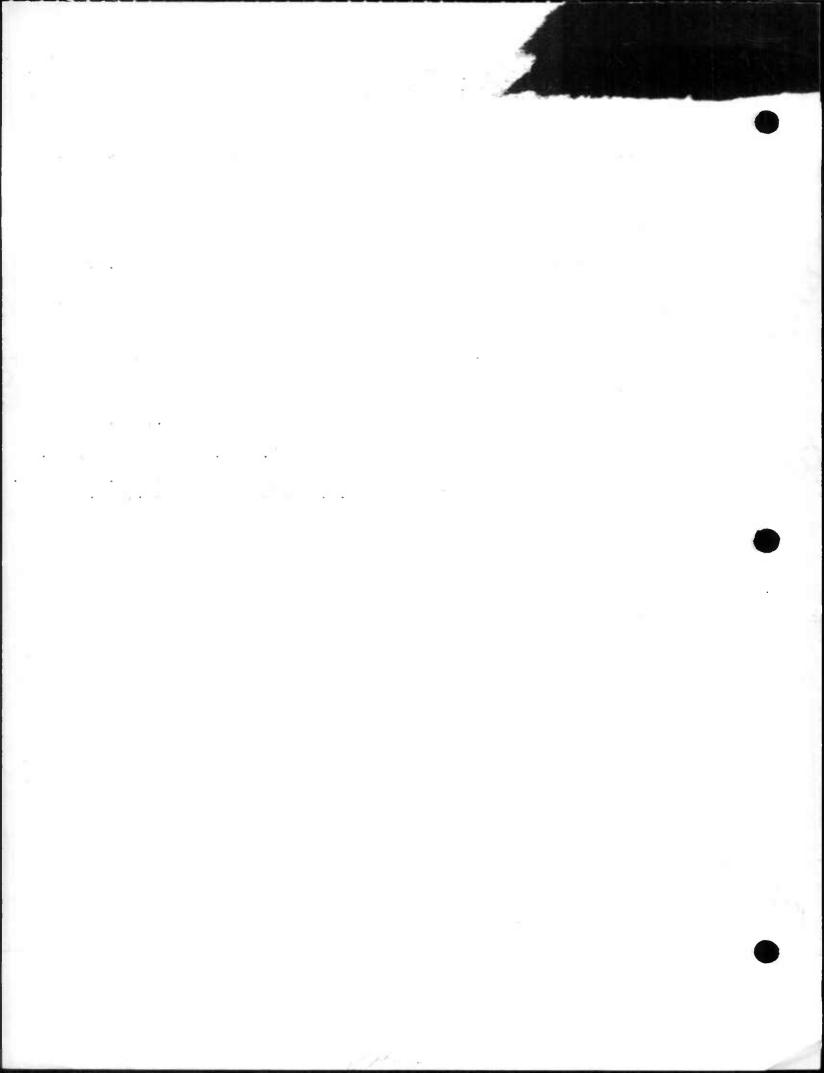
TO BE

BALLIMORE, MARYLAND 21215-0020	rSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, 7:0. BOX 867 60.	TO THE HOSPITAL OH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 r	TO THE REPORTED ENGINEEDRY. After this certificate has been signed by the attending physician and completely filled in by the the filler within Z hours free death with the State Dept. of Health and Mental Hypiene prior to burial, cremation, or removal.	IMPORTANT IDNAM 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG NO

	1 - FOR STATE REGISTRAR		STATE OF N	MARYLAI	ND / DEPAR CERTIF					MENTA	L HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (FIRST, BEN 19mi		A. Tu	, 77	-					2. DATE MONT	OF DEATH	W	YEAR 95	3. TIME OF DEATH
	Benjamin A. TUTT 4. SOCIAL SECURITY NUMBER 218 12 7495 1 M M 2 F 72 YRS.						1 YEAR DAYS	I IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 4//7/2 8. BIRTHP Caunity) 4//7/2			HPLACE (State or Foreign			
	9a. FACILITY NAME (If not in	astitution, give s	treet and number)			9b. CITY,	TOWN C	R LOCATI	ON OF DI				N/A	
	RESIDENCE OF DEC	10b. COUNTY	,		100 011	Y, TOWN O	1)6	101					IN / F	
	MD	N/			100.01	Bal	+	ASV						10d. INSIDE CITY LIMITS? 1 2 YES 2 NO
	3807 Fe							212.				10g. CIT		WHAT COUNTRY?
	11. MARITAL STATUS 1. Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES MAR OR DATE	.S. ARMED 2 NO	l II	yea, sp	ENDENT Cook	in, Maxica	n, Puerto	N? (Specify Yea Rican, etc.)	or No—	Blac	E — American Indian, k, White, atc.
	(Specify only Elementary/Secondary (8	EDENT'S EQU y highest grade 0-12)	College (1-4 or 5	•)	(Give kind of life. Do NOT u	work done di se retired.)	luring mo	st of working	ng	168	. KIND OF BUS			
	12th 17. FATHER'S NAME (First, M.	irddle, Last)	4yrs.		Trucl	k Dr:	ıve		HER'S NA	ME (First,	Clot		g	
	Unknown 19a. INFORMANT'S NAME (7)	ime/Brist)			T 405 MAN 1110	1000000					evett			***
	Marie Ro	berts	on		380	7 Fe	rnh	ill		enue		ο.,	MD.	21215
	20a. METHOD OF DISPOSITION 1 Durial 2 Cremation 3 Ramoval from State 2 Ob. PLACE AND DATE OF DISPOSITION (Name of completery, cremation or other space) Carrison Forest Vet. Cem. Owingsmills, MD.								own, State					
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ensee Lector	CFS	P #281			o addre						Monroe St.
	23. PART I. Enter the di shock, or h iMMEDIATE CAUSE (Find disease or condition resulting in death)	esrt fallure.	List only one ceu	nev i	the deeth. Do th line. MINITED TO THE OWNSEQUENCE OF		the mo	de of dy	ing, suc	h es cen	diac or reepi	ratory er	rest,	Approximate interval Between Onset and Death
	Sequentially list conditi if sny, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or Inju- thet initiated events resulting in death) LAS	lons, diete iNG iry	c		ONSEQUENCE O									
	PART II. Other algnifice	nt condition	s contributing to	death but	not regulting	In the und	deriyinç	g cause (given in	Part I.	24a, WAS AN PERFOR 1 YES 2	MED?	241	D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF GEATH? 1 YES 2 NO
	DID TOBACCO U		RIBUTE TO CA		DEATH YI			UNC	ERTAI	v 🗆				
	EXAMINER?		HOSPITAL:			OTHER	li .	e 5 🗆 Re	sidenca	6 🗆 Othe	er (Specify)			
The second second		Pending Investigation	28a. OATE OF (Month, D		28b. TIN	NE OF JURY M		URY AT RK? YES 2	□ NO	28d. OE	SCRIBE HOW II	JURY OC	CUREO	
	3 Suicide 6	Could not be determined	28a. PLACE O building,	F INJURY — atc. (Specify)	At home, ferm,	atreet, facto	ory, office	•		28f. LOC City	ATION (Street a or Town, State)	nd Numbe	or or Rural	Route Number,
			CIAN: To the best of R: On the basis of a											a) and manner as stated,
	200. SIGNATURE AND TITLE	OF CENTRESES		≥ ,	np				ENSE NUI					(Month, Day, Year)
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7	PHYSICIAN:
DIVISION	ATTENDING PHYSICIAN:
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_	HOSPITAL

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		FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTAL HYGIEN	_			
		1. DECEDENT'S NAME (First, Middle, Last)		02.11111	IOAIL OI	DEATH	2. DATE OF DEATN			TIME OF DEATH	
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		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (II	n yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN	8.	BIRTHPLA	CE (State or Foreign	
_		012-32-5637A	1 M 2 0 F 9:	1 чяз.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Sept. 20,	1903 H	Country) R1155i	a	
3 should		9a. FACILITY NAME (If not institution, give str	eet and number)		9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY			
60	8	Hebrew Home Of G	reater Washi	noton	Rock	ville		Monte	romer	^v	
physician. burial-transit permit. Pages 1, 2,	DIRECTOR	Hebrew Home Of G	LCGLOT WGBILL					110110			
Page	1 2 1			10c. CIT	Y, TOWN OR LOC				100	I. INSIDE CITY LIMITS?	
ij.		Maryland Mont	gomery		Rockvil				- 21	YES 2 NO	
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	B	3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DA	TES 22	1 _ YE	S 2 NO Specif	у:		Specify:	White	
al or attending physician for use as the burial-tra	유	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S			16b. KIND OF BUS	SINESS/INDUS	TRY	WW. I CO	
6 7		(Specify only highest grade (Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(Give kind of a life. Do NOT us	work done during n se retired.)	nost of working					
spita hed 1	립	12 Yrs		Housewif	e		Own Ho	ome			
the hospital detached fo	COMPLETED	17. FATNER'S NAME (First, Middle, Last)			-	18. MOTNER'S NA	ME (First, Middle, Maiden	Surname)			
8 8 6	BEC	Charles Shulman				Ida	(Unknown)				
5 should	원 원	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tow	n, State, Zip Co	de)		
		Irene D. Magazine		7454 N	l. Devon	Drive,	Tamarac, F	lorida	3332	21	
may be		20a. METNOD OF DISPOSITION 1 Surial 2 □ Cremation 3 □ Ramo	20b.					CATION — City			
Page 6 may all director, pa		4 Donation 5 Other (Specify)	Jen	wish Ber	ievolent	Vame of 3/09/ Cemeter	West	t_Roxbu	urv.	MA	
		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		CTETN	AND ADDRESS OF FA	MEMORIAL F				
		Conold (Stattler	nues			T, NW, WASI				
d in by the or removal.		23. PART 1. Enter the diseeses, or c	omplicatione that caused	166 death. Do						Approximete	
ompletely filled in by the completely filled in by the incremove event, the medical		shock, or heert fellure. L	ist only one cause on ea	ch line.					'	Interval Batween Onset and Daath	
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executed and com o burial, natic ev	z	DÉMENTIA YEAR									
te be execute sician and co prior to buria traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A		F):						
ysiciar prior trau	3	cause. Enter UNDERLYING CAUSE (Disease or injury									
eath certificate be attending physician trail Hygiene prior to y, or other traun	띹	that initieted events	DUE TO (OR AS A	CONSEQUENCE O	F):						
attending that Hy	H	resulting in death) LAST									
	C	PART II. Other significent conditions	contributing to deeth bu	it not recuiting	in the underlyi	na ceuse alven in	Part I. 24a. WAS AN	AUTOPSV	24h WE	RE AUTOPSY FINDINGS	
SICIAN: The law requires that the certificate has been signed by the the State Dept, of Health and Me. or item 23 shows any Injuri	MEDICAL	STROKE	-				PERFOR	PMED?	AMA	ILABLE PRIOR TO MPLETION OF CAUSE	
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requires been signi of Healt		DID TOBACCO USE C	ONTRIBUTE TO	ALISE OF	DEATH Y	YES IT NO			10	YES 2 NO	
has the Dept	SICIAN:	25. WAS CASE REFERRED TO MEDICAL	OTTIMISOTE TO C	- OI		[
CIAN: The striffcate he State D	12	EXAMINER?	HOSPITAL:	39	OTHER:	PLACE OF DEATH (Ch					
certifie	Å.	27. MANNER OF DEATN	1 Inpatient 2 ER/Outpa	285. TIM		NJURY AT	8 U Other (Specify) 28d. DESCRIBE NOW I	N ILIEN OCCUP)FD		
PHY SE ST	-	1 Natural 5 Pending	(Month, Day, Year)		IURY W	YES 2 NO	200. DESCRIBE NOW I	NJUNT OCCUM	EU		
After this of death with	TO !	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, term.			28f. LOCATION (Street	and Number or	Dural Doub	Alumber	
TTEN TOR: after	1	4 Nomicide 8 Could not be	building, etc. (Special	fy)			City or Town, State)		TOTAL PROGRE	rvariasei,	
DR A DIRECTORIES	LET	29a. CERTIFIER 1 TO CERTIFYING PAYER	YAN: To the best of a large	des dies		- 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10		- 11-2			
4 4 Z =	COMPL		EIAN: To the best of my knowled: On the basis of examination						aumodat :		
HOSPITAL FUNERAL within 72					, iii iiiy opiiii01,	_					
를 발 를 등	BE	296. SIGNATURE AND TITLE OF CERTIFIER	M.D.			29c. LICENSE NUI				onth, Day, Ybar)	
223	2	30. NAME AND ADDRESS OF PERSON WHO		TN /ITEM 27) /3	Delast)	D 36	277	MAK	~~n	8 1995	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

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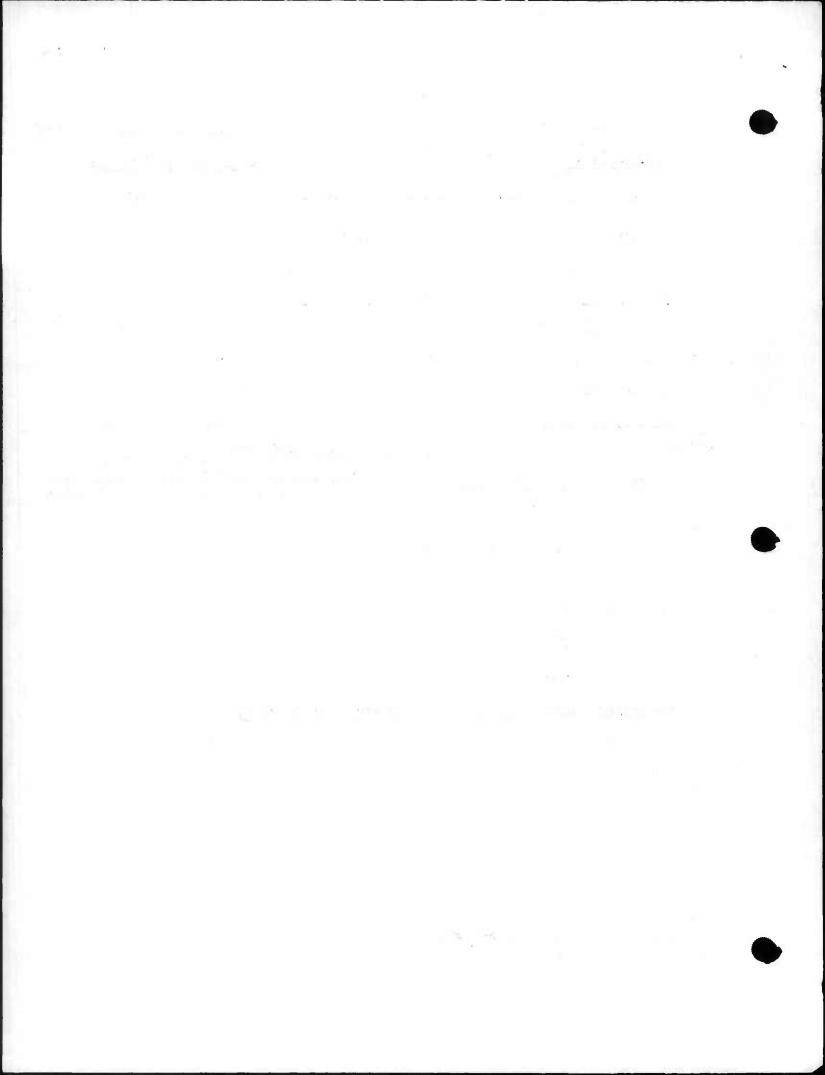
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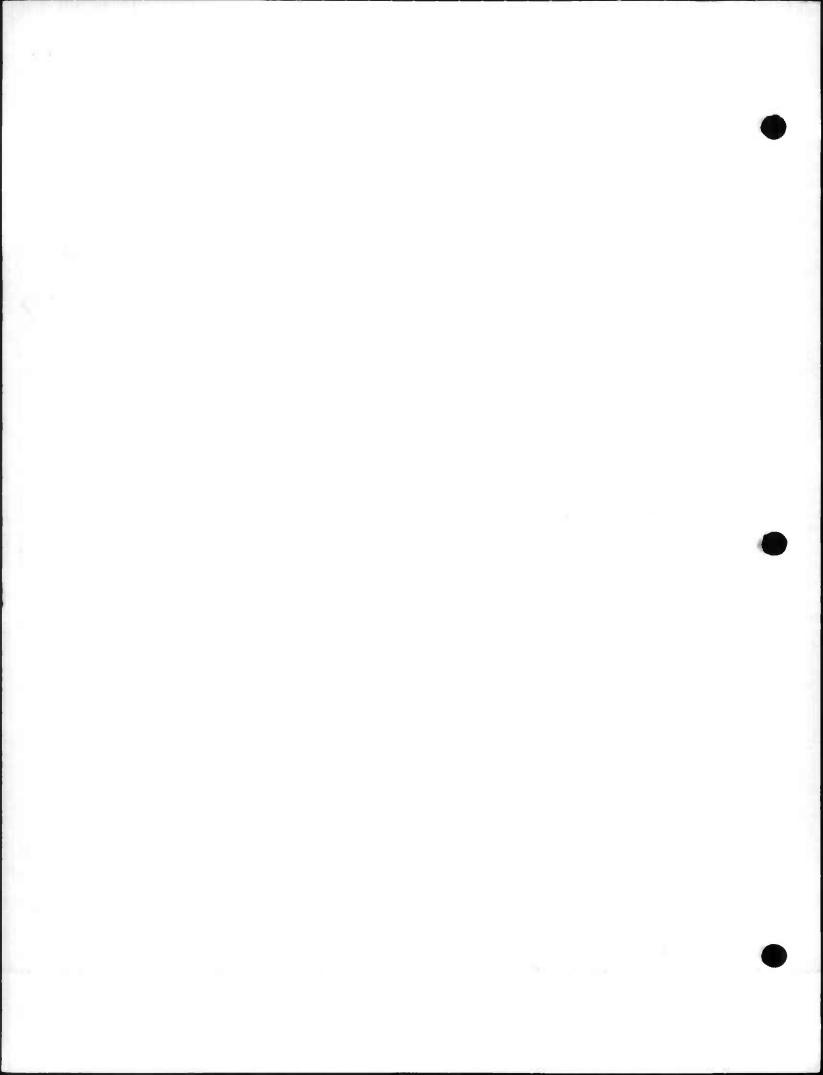
32. REGISTRAR'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memail Hygiene prior to burial, cremation, or removal.	MONITARY: If these 39 to sentent or these 32 should be added to a sentent of the
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	FOR STATE REGISTRAR	STATE OF N	IARYLAN	D / DEPAR					MENT	AL HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last) ERMA		EN(2. DA	TE OF DEATH DO	Š (75	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 285-07-3043	5. SEX	6. AGE (In y	rs. last birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER HOURS	24 HRS.	7. DAT (Mo A U	re of BIRTH with, Day, Year)	1915	6. BIRT Coun Oh	HPLACE (State or Foreign try)
1 -	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, T			ON OF DE	ATH		9c. COU	NTY OF	DEATH
P	Crofton Conv.	Center			Cro	fto	n				Ann	e A	rundel
DIRECTOR	MD 10a. STATE 10b. COUNT Anne				y, town on erna		ark						10d. INSIDE CITY LIMITS? 11/2 YES 2 \(\text{NO} \) NO
FUNERAL	9 Holly Road						146	E				ZEN OF	WHAT COUNTRY?
₽	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	S 2 12 NO If yes, specify Cuben, Mexican			NIC ORIGIN? (Specify Yes or No.— 14. RACE an, Puerto Rican, etc.)			E - American Indian, ck, White, etc.			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of w life. Do NOT use retired.) HOUSEWIFE			N t of workin				HO	me	
	8 17. FATHER'S NAME (First, Middle, Last) John Nagy			- Cabew	110		Jul	ia (ME (First	t, Middle, Maiden		110	iii C
TO BE	19a. INFORMANT'S NAME (Type/Print) Donna V. Kish			196. MAILING 9 HO	ADDRESS (S	Street an	d Number	or Rural R Seve	ern	mber, City or Tow a Par	n, State, Zir.	Code)	21146
	1 Burial 2 Cremation 3 Removal from State cemetery				ACE AND DATE OF DISPOSITION (Name of y, cremetory or other place)			OATE 20c. LOCATION — City or Town, State			·		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	CDISEE /	Wes	t Par				S OF FAC		11 Cl	<u>evel</u>	and	, OH
аури	Pot h	1 (bond)	1		Наз	rde	stv	Fu	ner	al Hor	me,	P.A	MD 21401
1000	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ASA TOTAL A PROBLEM WAY A DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):												
PHYSICIAN: MEDICAL C	PART II. Other significant condition Hypertenicon	Dy Charta			Part i.	24e. WAS AN PERFOR	MED?	24	b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
IAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					26. PL/	ACE OF D	EATH (Che	ck only	one)			
YSK	1 TES 2 DATO	HOSPITAL:	ER/Outpatie	nt 3 🗆 DOA	OTHER:	g Home	5 🗆 Re	sidence	5 🗆 Oti	her (Specify)			
K	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, De		28b. TIM INJ	E OF 26	Bc. INJU WOF		NO	28d. O	ESCRIBE HOW II	NJURY OC	CURED	
ETED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							Route Number,					
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS												e) and manner as stated.
296. SIGNATURE AND STEER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29c. LICENSE NUMBER							BER 2		29d. DAT	E SIGNE	O (Month, Day, Year)		
1	30. NAME AND ADDRESS OF PERSON WITH THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE TOTAL THE T	CNAH	8101	rell, 14	Print) (3 A)	NN	HPUL	is	Rol	40 #1	06,0	DEN	TON MD
	31. DATE FILED (MONTH, Day, 16ar) MAR 1 0 1995	32. HEGISTINA	ON COMMENT	all.							ŧ.		21113



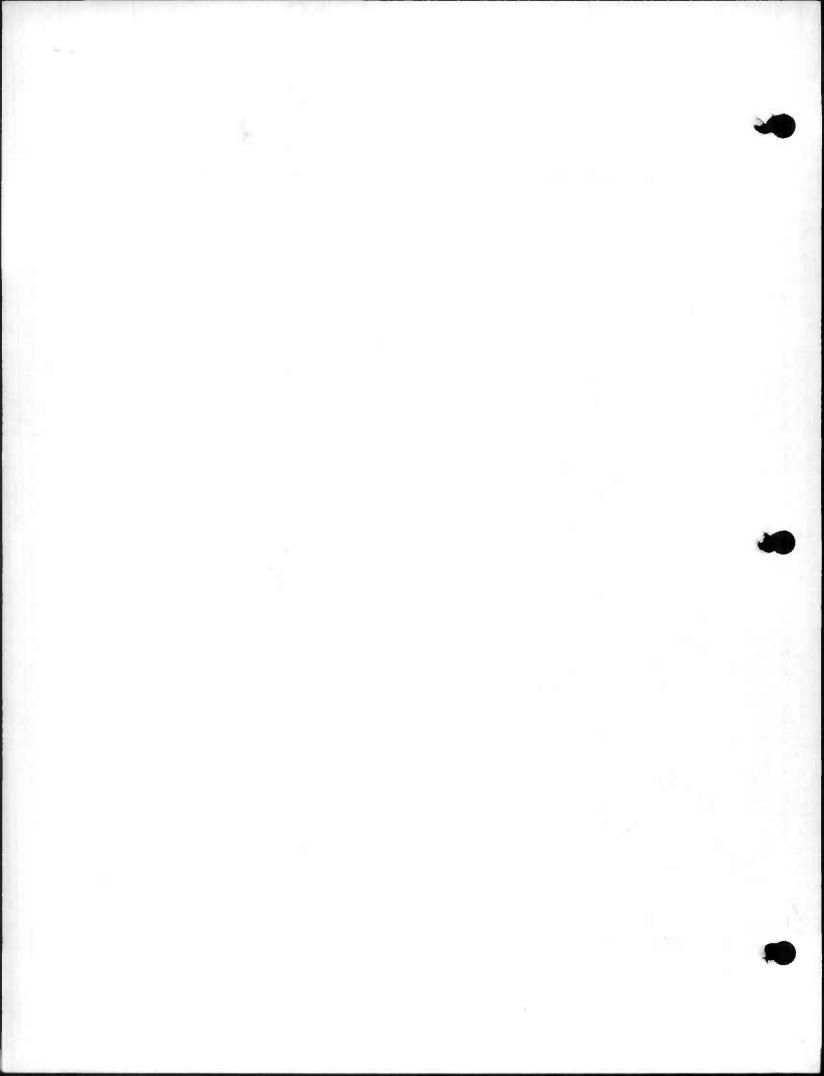
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rial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the law after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely inted in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND	DEPARTMENT OF	HEALTH	AND	MENTAL	HYGIENE
C	ERTIFICATE O	F DEAT	ГН		REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			ENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)	WILSON				2. DATE OF CEATH DA	y gr	3. TIME OF OEATH		
	4. SOCIAL SECURITY NUMBER 212-12-2995	6. SEX 6. AGE (UNDER 1 YEAR	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 17,	1923	BIRTHPLACE (State or Foreign Country) Maryland		
	Se. FACILITY NAME (If not institution, give	•		CITY, TOWN O	R LOCATION OF DEA		9c. COUNTY			
DIRECTOR	Laurel Beltsville	Regional Ho	spital]	Laurel		Princ	ce Georges		
HE	Market and Dain		10c. CITY, To	OWN OR LOCAT				10d. INSIDE CITY LIMITS?		
	Maryland Prin	ce Georges		Laui 101.	ZIP CODE		10g. CITIZEN	1 ☑ YES 2 ☐ NO OF WHAT COUNTRY?		
FUNERAL	14807 Bowie Road	Apt. 204			2070			USA		
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, spe	ENDENT OF HISPANIC city Cuben, Mexican, 2 NO Specify:	C ORIGIN? (Specify Yea Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: Black		
ELED	15. OECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. OECEDENT'S USI (Give kind of work life. Do NOT use re	done during mor	N t of working	16b. KIND OF BUS	INESS/INDUST			
COMPL	7th Grade 17. FATHER'S NAME (First, Middle, Lest)		Grounds	keeper	46 MOTHER'S NAM	Meadow.		Cemetery		
BE CC	Richard Wilson, J	r.				Henson	Surname)			
0 8	19a. INFORMANT'S NAME (Type/Print)					oute Number, City or Town				
	Louise Wilson	201	. PLACE OF DISPOSITE		oad Apt.		urel., I	Maryland 20708 or Town, State		
	1 N Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	E	other place) Lkridge Co	mmunit	Church	Marl Ho	ward C	ounty, MD		
	21. SIGNATURE OF FUNERAL SERVICE L	Parker	/			Nutter 11s Parkw 11s 21		1 Homes, Inc		
	23. PART I. Enter the diseases, or shock, or heart failure	complications that cause List only one cause on e	ach line.				ratory arrest,	Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. VEY TWULAN ARRYTHMIA Due to lost and Death Onset and Death									
,	- COOSIAD VADTERY DITASE									
RIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):							
FIC	CAUSE (Disease or injury that initiated events	C DUE TO (OR AS A	CONSEQUENCE OF):							
SER	resulting in death) LAST	d								
AL.	PART II. Other significant condition	ns contributing to death a	out not resulting in t	the underlying	cause given in P	Part I. 24a, WAS AN		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
MEDIC	ASEA MA ENDS INC.	C 140 CVLIII	10			1 [] YES 2	NO	OF DEATH?		
								10 10 10		
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:	ACE OF DEATH (Chec					
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O			28d. DESCRIBE HOW I	NJURY OCCUR	ED		
2 Accident Investigation 2 Accident Suicide S Could not be determined M 1 YES 2 NO 286. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Street and Number or Flural City or Town, Street								Sural Floute Number,		
COMPLE	noni	SICIAN: To the best of my know						suse(s) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIC	halv			29c, LICENSE NUM	037	29d, DATE SI	GNED (Month, Day, Year)		
2	SO, NAME AND ADDRESS OF PERSON W	100 321	NVE P	"GE DR	LE ST	LAUNA	MD 2	10907		
	MAR 1 0 1995	all distribution has	Wally							



	}			
BALTIMORE, MARYLAND 21215-0020	er death. Page 6 may be retained by the hospital or attending physician.	he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not.	i examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumstic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 WNO

5 Pending Investigation

27. MANNER OF DEATH

1 Netural

2 Accident 3 Sulcide

4 Homicide

	1tem2 3-10-95 FilmG/21 W.H.Per F/H	07516
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.	
	Myrt16 E WAddy	3. TIME OF DEATH
	216-22-4863 10 M 2 XF 82 YRS. MONTHS DAYS HOURS MIN. 198 1912 Country	ginia
5	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DE PESIDENCE OF DECEDENT 96. COUNTY OF DE	ATH
Dine		10d. INSIDE CITY LIMITS? 1 YES 2 NO
MEDAL	28 8 Brighton Street 101. ZIP CODE 10g. CITIZEN OF W.	AT COUNTRY?
ם זם	11. MARITAL STATUS 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 YES 2 NO	- American Indian, White, etc.
Mrtelet	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) College (1-4 or 5+) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of working life. Do NOT use refired.) College (1-4 or 5+)	wdustry
20	17. FATHER'S NAME (First, Middle, Last) Charles Dorsey Mary Yerby	
2	Stanley Waddy 2133 N. Fulton Acrye Baltim	ore Maryland
V	206. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of cametery, cremetery, cremete	n, State
	22. NAME AND ADDRESS OF FACILITY LIVIN CARNOL 1712 W. No	rth Avenue
	23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiretory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final	Approximate Interval Between Onset and Death
	disease or condition resulting in death) a. Attenose length Cardiovaseular Disease Due to (OR AS A CONSEQUENCE OF): b. Tutulin Dependent Diabetes Mellitary	Zyn.
11011	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A GONSEQUENCE OF):	yrs.
2	CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):	
;	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s, WAS AN AUTOPSY 24b, V	WERE AUTOPSY FINDINGS

Pergleral Vaseular Dis case

HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA

28e. DATE OF INJURY (Month, Day, Year)

1 | YES 2 10 10

28d. DESCRIBE HOW INJURY OCCURED

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

28. PLACE OF DEATH (Check only one)

6 Could not be determined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	281. LOCATION (Street end Mumber or Rural Route Number, City or Town, State)

26b. TIME OF

29a. CERTIFIER
(Check only one)

PT MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner se stated. ADI MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)

3/1/95

OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)

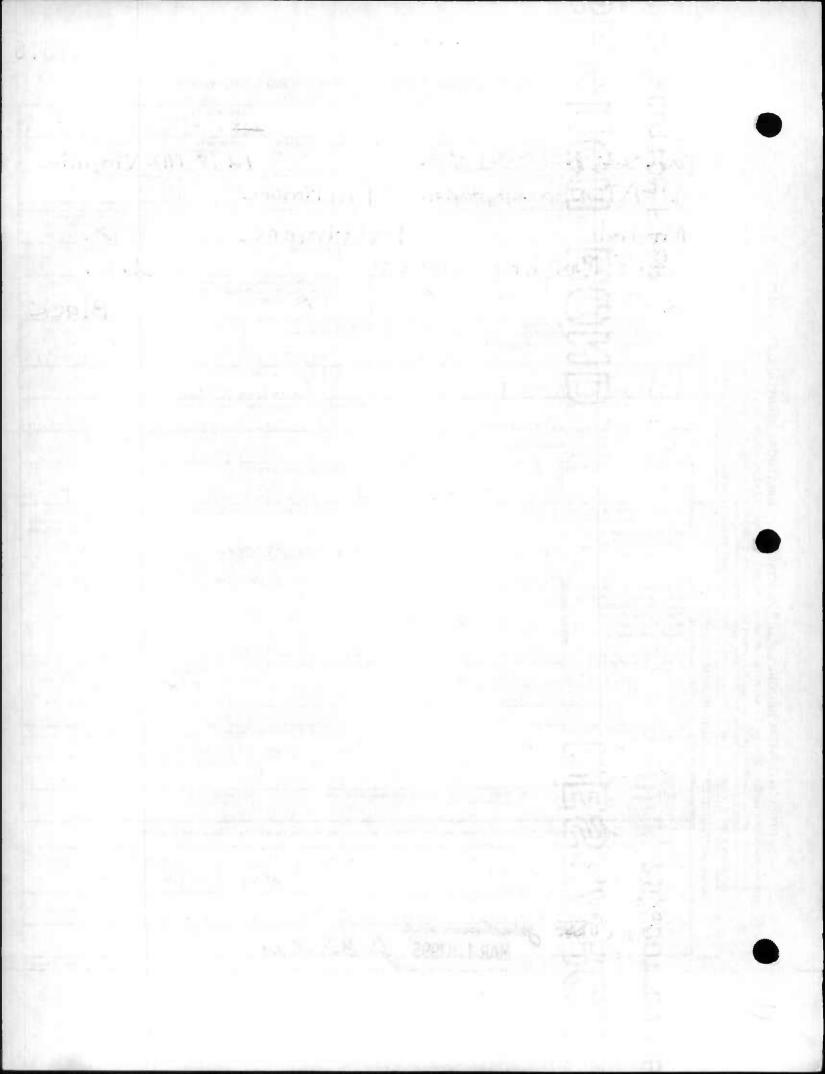
28c. INJURY AT WORK?
1 YES 2 NO

Surplate WD	29c, LICENSE NUMBER D19858	29d.
TEOTRE TELLER, NEW BLANCE OF DEATH (ITEM 27) (Type, Print)	~ ./	2.20

State Character and an analysis of

Julia danily or Randal

DHMH-16 Rev 1/89



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

BY PHYSICIAN: MEDICAL CERTIFICATION

COMPLETED

BE

2

27.

4 Homicide

I	tem # 1 Film # g 721 3-10-95 N.A.	Per fun	eral h	nome						2	J	0/0//
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
FUNERAL DIRECTOR	1. DECEDENT'S NAME (First, Middle, Last) John A. Wesolow				ski			2. DATE OF DEATH		*8 9.	YEAR	3. TIME OF DEATH 4.'00 1
	215-14-4131 Z = F	2 M 2 □ F 73 YRS.		IF UNDER	1 YEAR DAYS	IF UNDER	8494	(Month, I	DATE OF BIRTH (Month, Dey, Year) Oril 6,1921		8. BIRTHPLACE (State or Foreign Country) Maryland	
	9s. FACILITY NAME (If not institution, give street and number) University Hospital				96. CITY, TOWN OR LOCATION OF DE Baltimore				ATH 9c. CO		OUNTY OF DEATH	
	Maryland Baltimore	DUNTY 10c. CITY			r, town or Location Kingsville						10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
NERAL	5 Elray Road	10o. STREET AND NUMBER 5 Elray Road					10f. ZIP CODE 10g. CITIZEN OF V 21087 U.S.					
TO BE COMPLETED BY FUR	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WA		WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ★ NO Specify: White, Specify: White					- American Indian, White, atc.				
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5+) 4	s USUAL OCCUPATION work done during most of working see relied.) U. S. Treasury										
	17. FATHER'S NAME (First, Middle, Lest) John Wesolowski Balbina Ruzylo											
	196. INFORMANT'S NAME (Type/Print) Frances M. Wesolowski (wife) 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Elray Road, Kingsville, MD 21087											
	20e, METHOD OF DISPOSITION 1 (2) Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	cofficience of the place of the										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE					Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236						
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, ahock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in daeth) DUE TO (OR AS A CONSEQUENCE OF):									Approximate interval Betwee Onset and Deat		
CERTIFICATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that infileted events resulting in death) LAST b. Massive Sepsis Due to (or as a consequence of): Multisystem Drg n Faylyse oue to (or as a consequence of): d.											
SAL .	PART ii. Other eignificant conditione contributing to d	eeth but not r	eculting I	n the un	deriying	ceuse (given in f	Part i. 2	e. WAS AN			WERE AUTOPSY FINDINGS

1 YES 2 NO

DESCRIBE HOW INJURY OCCUREO

COMPLETION OF CAUSE OF DEATH?

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)

1 - YES 2 - NO

	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 N	ER: ursing Home 5 - Residencs	8 Other (Specify)
MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HO

Natural
Accident
Suicide Could not be

M 1 YES 2 NO 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)

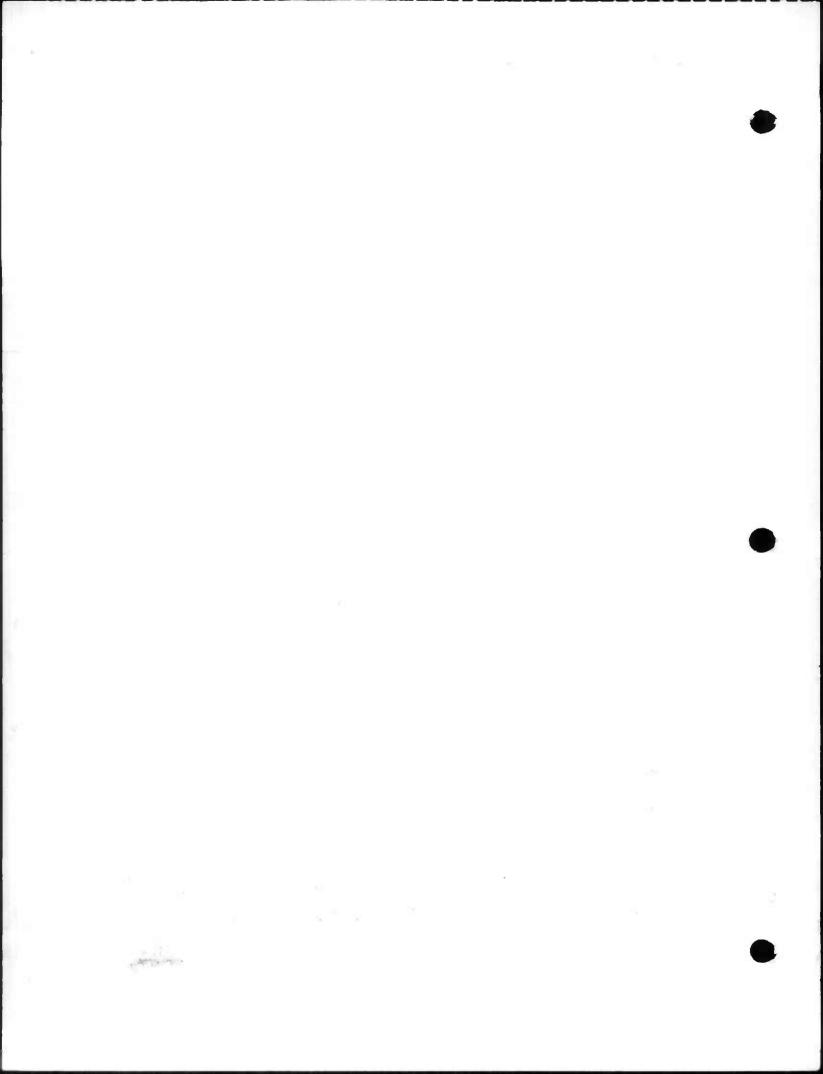
281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To this best of my knowledge, death occurred at the time, date end place, and dus to the cause(s) and menner as attated. (Check only one)

2 MEDICAL EXAMINER: On the basis 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

U4176435AT2818

BALTTMORE 21201



DIVISION OF VITAL RECORDS, P.O. BOX 68760

I or attending physician.	or use as the burial-transit permit, Pages 1, 2, 3 should		
hours after death. Page 6 may be retained by the hospital	filled in by the funeral director, page 5 should be detached	on, or removal.	ne medical examiner must be notified at once.
HYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	acertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should	In the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	id, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAL	TO THE FUNERAL QUELCION NEW THIS COTT!	be filed within 72 yours after death with the	IMPORTANT: II bene 28 to marked, or

30. NAME AND ADDRESS OF PERSON

11. DATE FILED (Month, Day, Year)

MAR 1 0 1995

									20	U	1010		
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR REGISTRAR													
	1. DECEDENT'S NAME (First, Midd	1. DECEDENT'S NAME (First, Middle, Last) James A. W						2. DATE OF DEATH MONTH DA	Y 0.5	YEAR	TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last		IF UNDER 1 YEAR	IF UNDER	24 400	03 06 95			4;30 A	. M	
	244-20-196		95	YRS.	MONTHS DAYS	HOURS	MIN,	(Month, Day, Year)	Ybar)			_	
	9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN O	OR LOCATIO	ON OF DE				Carolina	a	
DIRECTOR	1706 Thomas Avenue Baltimore N/A												
딥	RESIDENCE OF DECED 10a, STATE 10b	. COUNTY	10c. CIT	10c. CITY, TOWN OR LOCATION									
HO	MD.				timo	re		I. INSIDE CITY LIMITS?					
	MD. N/A Baltimore 100. STREET AND NUMBER 1001. ZIP CODE 1009. CITIZEN OF WH										_		
EB/	1706 Thoma	s Avenue				2121	.6			J.S.			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 FIF YES, GIVE WAR OR OATES				It yes, sp		n, Maxica	HC ORIGIN? (Specify Yas n, Puarto Rican, etc.)	American Indien, hita, atc. Black				
	15. DECEDENT'S EDUCATION 18a. C (Specify only highest grade completed)				USUAL OCCUPATION	ON set of workin	N7	18b. KIND OF BUS					
COMPLET	Elementary/Secondary (0-12)	ementary/Secondary (0-12) College (1-4 or 5 +)			Farmer			Fari					
ŏ	17. FATHER'S NAME (First, Middle,	•				18. MOTE	NER'S NA	NAME (First, Middle, Malden Surname)					
BE	Louis Williams Sal						all	ly Ann Scott					
2	196. INFORMANT'S NAME (TyperPrint) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1706 Thomas Avenue Balto., MD. 21216												
	20s. METNOD OF DISPOSITION 20s. DI ACS AND DATE OF DISPOSITION (Algored) 20s. To accompany to the control of th												
	4 Donetion 5 Other (Specify) complex frequency Riving Cemetery 3/95 Balto., MD.												
	21. SIGNATURE OF FUNERAL SEI	RVICE LICENSEE			22. NAME AN	D AOORES	SS OF FA	CILITY	1 27	NT M.	C	_	
	Nouth	a tector	CFSP #2	281	E.L.	Phi1	.lip	s F/H ¹⁷²	1-2/ lto	MD.	21217	L.	
	23. PART i. Enter the disease	ses, or complications th	at caused the de	ath. Do r	not entar tha mo	de of dyi	ing, suci	h ss cardiec or respi	ratory arres	st,	Approximate		
	IMMEDIATE CAUSE (Final		6			^					Onset and Des		
	disease or condition resulting in death)	. Hec	sut to	liW	re,	the	M	emia			4 Uc		
	DUE TO (OR AS A CONSEQUENCE OF):												
NO N	Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF):												
I K	cause. Enter UNDERLYING												
Ē	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):										_		
ERTIFICATION	resulting in death) LAST												
O	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
MEDICAL	PERFORMEO? AMAILABLE PRIOR TO COMPLETION OF CAU									ILABLE PRIOR TO			
	1 YES 2 DATE OF DEATH?												
	DID TOBACCO	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 7 NO 74											
IAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)												
SIC	EXAMINER? 1 YES 2 NO HOSPITAL 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify)												
PHYSICIAN:	27. MANNER OF DEATH 288. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED										\neg		
×	1 Natural 5 Pend 2 Accident Inves	iling itigation			M 1 🗆 1		NO						
1	3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home term, street, factory, office 28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
100	29a. CERTIFIER (Check only (Check only)												
СОМР	(Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.												
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)												
BE C	W13 Jochmoton (W) 122904 12-8-95												
유	30. NAME AND ADDRESS OF PER	10. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)											

MPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32, REGISTRAR'S SIGNATURE

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Page 6 may be retained by the hospital or attending physician. ALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	4 14
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	CODITAL OF STREETING COMMISSION THE STREET OF STREET

29b. SIGNATURE AND TITLE OF CERTIFIER

FOREST

30. HAME AHD ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Azmari

BE

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Catherine Gertrude Wittman 6-1995 Mar. 8:30 A 4. SOCIAL SECURITY HUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Yoar 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗌 M 2 🖵 F 214-12-3669 June 14. Maryland 1912 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 311 Baltimore Dr., Stevensville Oueen Anne RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Oueen Anne Stevensville permit. § 1 YES ZETNO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEH OF WHAT COUNTRY? 311 Baltimore Drive burial-transit 21666 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 YES 2 THO Specify 3 Widowed 4 Divorced use as the White ETED. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Homemaker Own Home 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) notified at Otto Deichgraber BE Gertrude Bayrle 19e. IHFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 311 Baltimore Dr., Stevensville, Md. 21666 Robert Wittman ě 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Cametery, Crematory or other place)
OakLawn Cemetery 3-10-95 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins Bradley-Ashton Funeral Home, examiner 8 line D00083 2134 Willow Spring Rd., Balto., Md. removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the attending physician and completely filled in by i Mental Hygiene prior to burial, cremation, or remo shock, or heart failure. List only one ceuse on each line Interval Batween IMMEDIATE CAUSE (Final Onset and Death DUE TO (OR AS A CONSEQUENCE OF):
Conormy Arty D2 the disease or condition resulting in death) 2 uks event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the Vajul de AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO 1 YES 2 HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN has be Dept. PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h EXAMINER? HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 10 27. MAHHER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT this c. 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Haturel 5 Pending 1 YES 2 NO BΥ After I 2 Accident Investigation 28e. PLACE OF IHJURY — At home, farm, street, lectory, office building, etc. (Specify) 3 Sulcide 28 is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined DIRECTOR: A COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTO be filed within 72 hours af IMPORTANT: If Item 21 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as atated,

2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(e) end manner se stated.

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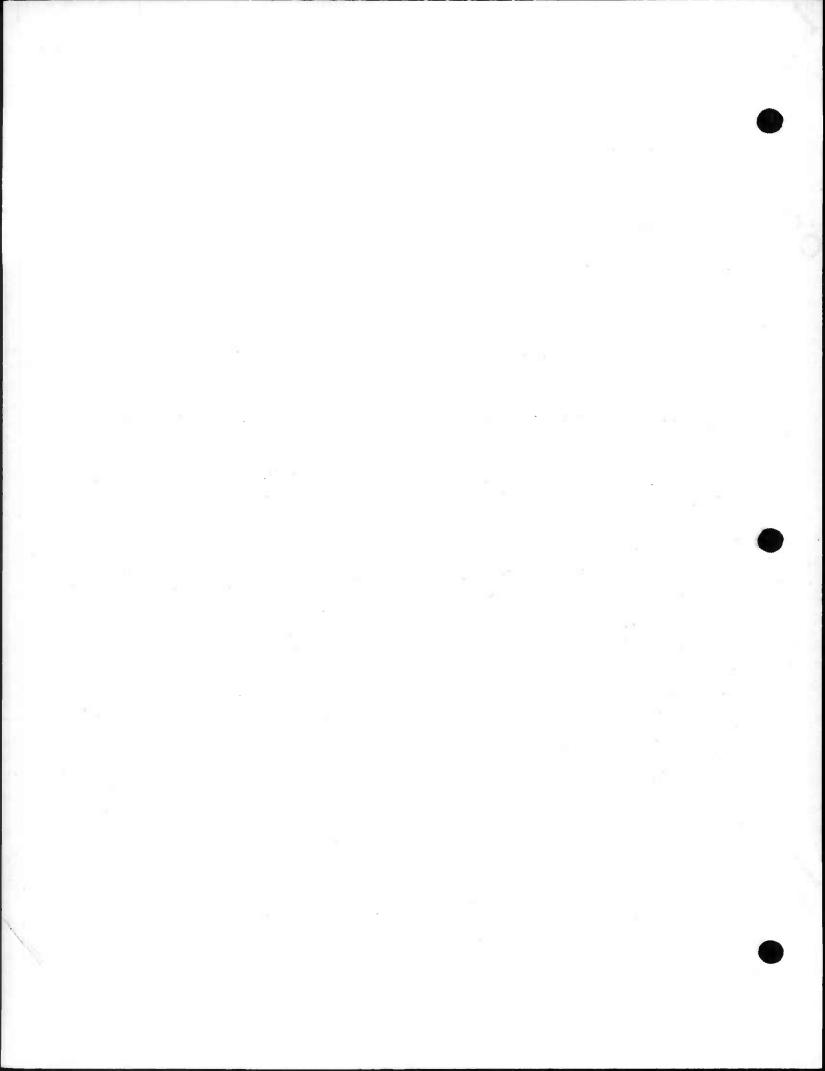
29c. LICENSE HUMBER

21401

29d. DATE SIGNED (Month, Day, Year)

		HEGISTHAH				CER	TIFICA	IE C	IF DEP	VI H		REG. NO			
		1. DECEOENT'S NAME (First,									2. DAT	E OF DEATH	AV .	YEAR 3	. TIME OF DEATH
				am Josep							-	ch 07.	1995		3:30 p M
		4. SOCIAL SECURITY NUMBER 213-64-4783		5. SEX		In yrs. last birti	MONT	DER 1 YE		MIN.	7. DATE (Mon	E OF BIRTH oth, Day, Year)	8	BIRTHPL Country)	ACE (State or Foreign
형				1 XM 2 F	42	У	rs.					. 20, 1			ryland
3 should	œ	9a. FACILITY NAME (If not ins	titution, give s	treet end number)			9b. C		VN OR LOCA				9c. COUNT		
Ñ	СТОВ	RESIDENCE OF DEC						Ra	ndall	Stown	1		Bal	timo	re
Jes 1,	E C	10e. STATE	10b. COUNTY	7		10	c. CITY, TOW	N OR LO	CATION					1	od. INSIDE CITY
2	DIRE	Maryland	Ba1	timore					Randa	11sto	own			1	LIMITS?
permit, Pages	AL	10e. STREET AND NUMBER	_						101. ZIP CO	DE			tog. CITIZE		AT COUNTRY?
ışı	FUNERAL	4 Aldersgate	e Cour	t						21133	3	USA			
or attending physician.	5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN	U.S. ARMED						IN? (Specify Yes	or No- 14	. RACE -	- American Indian, White, atc.
ing physic the burial	BY	1 Never Married 2 1 1 3 Widowed 4 Divor		IF YES, GIVE V	AR OR DA	TES			, specify Cut YES 2 NO			rtican, atc.)		Specify:	
as th			EDENT'S EDU	CATION		46- 050501	1	0.00110							ite
Z I Z I	COMPLETED	(Specify only	highest grade	completed)		(Give ki	ENT'S USUAI ind of work do NOT use retire	ne during	MATION most of work	dng	18	b. KIND OF BU	SINESS/INDUS	TRY	
pital o	2	Elementary/Secondary (0-	-12)	College (1-4 or 5			h Car				n	1			. 4
the hospital detached for	8 0	17. FATHER'S NAME (First, Mic	ddle, Last)			iieai (II Car	e w		THER'S NA		sychiat		OSD1	tal
# & & &		Donald	l Alle	n Wootto	n			18. MOTHER'S NAME (First, Middle, Meiden Surname) Catherine Mary Murdock							
retained to should be should notified	BE	19e. INFORMANT'S NAME (Type/Print)					AILING ADDR	ESS (Str				nber, City or Tow			
2 - 0 5	욘	Cheryl Kathl	leen B										3		
P 8 4		Cheryl Kathleen Buckstein 4 Aldersgate Court Randallstown, MD 21133 10 a. METHOD QE DISPOSITION 1 Burlet 2 N Cremetion 3 Removal trom State Camelor, cremetor or other place) 20 b. PLACE AND DATE OF DISPOSITION (Name of camelor) or other place)													
2 e e e		Doneston 5 Other (Specify) Metro Crematory, Inc. 03/08/99 Raltimore MD													
death. Pag tuneral di. I. examiner		21, SIGNATURE OF FUNERAL	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald Cremation Society of Maryland, Inc.												
death. e funera		> 4) aumo	4 M	comal	el			200	Frod	1 SOC	rety	7 OI Ma	ryland	1, 1	nc.
E 3 & at	П	23. PART I. Enter the dis	seeses, or c	omplications tha	t ceused	tha death.	Do not en	ter the	mode of d	ving, suc	h as cer	Balt	Imore	MD	Approximats
or in		shock, or he IMMEDIATE CAUSE (Fine	art fellure.	Liat only one cau	se on ea	ich iina.									Interval Between Onset and Death
within 24 I upletely fille cremation, vent, the		disease or condition	> V	1 12	es.	- 400	Tois	1.0							Oliset sild Death
completely ial, cremati		disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):													
executed and com to burial, matic even	z	Sequentially list conditions, b. Terming ASPS with Westing synthone, chavic areain													
e execu an and r to bur	일	If any, leading to immediate													
eath certificate be execute attending physician and crutal Hygiene prior to buriary, or other traumatic.	FICATION	CAUSE (Disease or injury													
n certifica nding ph Hygiene	RTIF	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
eath cattend attend tal Hy	CER	d													
E Me		PART ii. Other significan	nt condition	s contributing to	deeth bu	it not resul	ting in the	underi	ying ceuse	given in	Part I.	24s. WAS AN			ERE AUTOPSY FINDINGS
that the army	EDICAL			1,25								PERFOR		C	MAILABLE PRIOR TO OMPLETION OF CAUSE
Sign Wires	MEC			* 1							_		A		F CEATH?
e law requi has been s Dept. of H	ä	VDID TOBACCO US	SE CONTI	RIBUTE TO CA	USE OF	F DEATH	YES [NO	DY UN	CERTAIN	V П				
ATTENDING PHYSICIAN: The law requestions that this certificate has been a safer death with the State Dept. of 128 is marked, or 11em 23 sho	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	2	6. PLACE OF			ne)						
iclan: ertifica the Str	YSI	1 TYES 2 NO		1 Inpetient 2	ER/Outpar	itient 3 🗆 D	OA 4 1		lome 5	Residence	8 🗆 Oth	er (Specify)			
this ce with the rked,	PHY	27. MANNER OF DEATH 1 Natural 5 P	and an	28e. DATE OF (Month, D		288	b. TIME OF	28c.	INJURY AT WORK?		28d. DE	SCRIBE HOW II	NURY OCCUP	RED	
DING PHYS After this death with	B≼		rending				M		YES 2	□ NO					
OR ATTENDING DIRECTOR: After hours after death			could not be	28e. PLACE O building,	F INJURY - atc. (Specif	— At home, f fy)	erm, street, t	actory, c	ffica			CATION (Street e or Town, State)	nd Number or	Rural Rou	te Number,
OR AT DIRECT hours a	E I	20- CERTIFIED V													
3 - 2 -	Ē.			CIAN: To the best of											
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	COMPL	one) 2 🗀 MEDIC	AL EXAMINE	R: On the basis of a	camination	end/or Invest	tigation, in m	y opinio	n, death occu	ared at the	time, date	e end place, en	d due to the c	ause(e) e	nd menner ee stated.
HE HE FI	BE	296. SIGNATURE AND TITLE	OF CERTIFIER	^					29c/LIC	ENSE NUN					fonth, Day, Year)
TO THE HOSPITA TO THE FUNERA be filed within 72 IMPORTANT: II	6	(~	5	10					V 9	372	99		▶ Mar	ch C	8, 1995
		30. NAME AND ADDRESS OF		1.7											
		Carlos Page		The state of the s	Rea	ad St	_Suit	e 3	15. B	altin	nore	MD 21	201		
_		MAR 1 0 199	5 In	38 REGISTRA	H S GRI										
L		, 2 0 100													



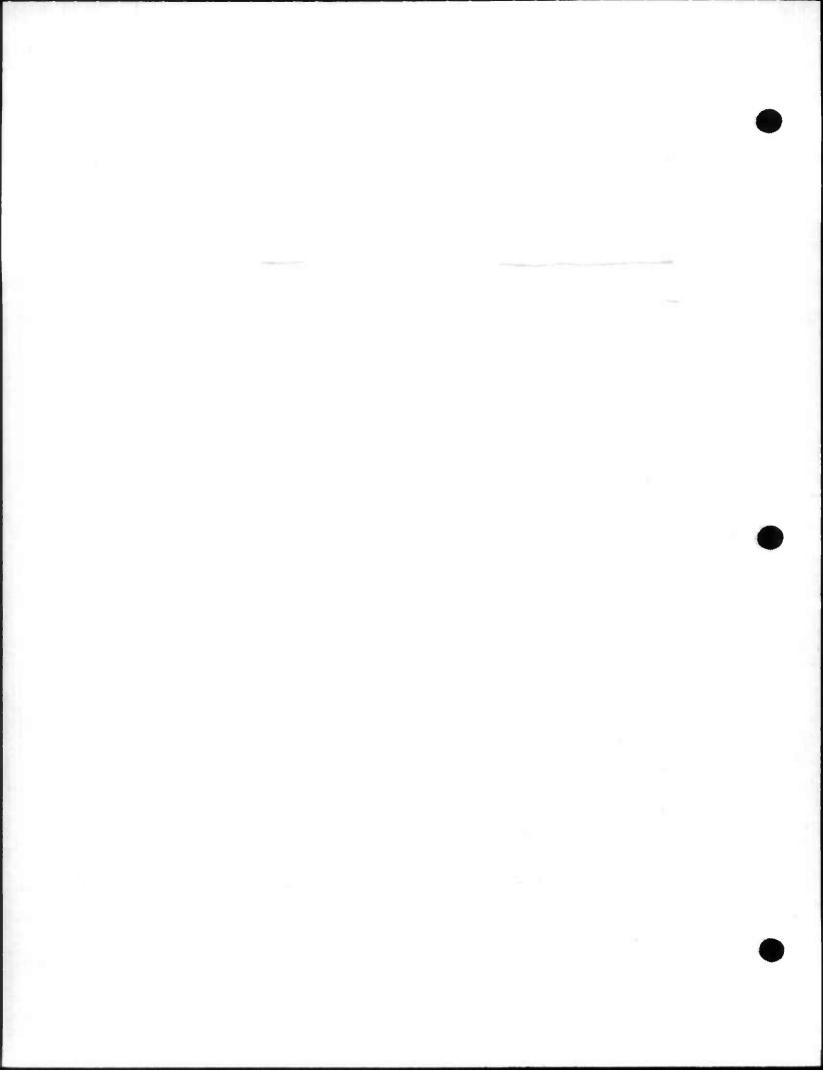


BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be **BOX 68760** P.O. DIVISION OF VITAL RECORDS,

permit. Pages 1, 2, 3 should use as the burial-transit retained by the hospital or attending physician. 5 should be detached for use as the burial-tran. # notified page 5 should å must funeral director, examiner in and completely filled in by the to burial, cremation, or removal. the medical event. traumatic the attending physician I Mental Hygiene prior to other 0 Signed by the been s has be Dept. OR ATTENDING PHYSICIAN: The law 23 After this certificate hadeath with the State D imarked, or item After death .00 FUNERAL DIRECTOR: within 72 hours after or 28 Item TO THE HOSPITAL TO THE FUNERAL IT DE filed within 72 h STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Ethe1 Watson Francis March 7,1995 5:25 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign HOURS DAYS 1 🗌 M 2 🖵 F YRS 212-36-3658 27, 87 Jan. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Lorien Frankford Nursing Center Baltimore City N/A 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore City YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3029 Chesterfield Ave 5009 Frankford Avenue 21206 21213 U.S.A 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 VES 2 NO 1 Never Married 2 Married It yes, specify Cuben, Mexican, Puerlo Rican, etc.) 1 TYES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only his Elementary/Secondary (0-12) College (1-4 or 5+) 11th Grade Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) Alfred Cormack Ada Welch BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Connie 305 Valiant Circle, Glen Burnie, Maryland 21061 Rhodes 20a. METHOD OF DISPOSITION
1♥ Burial 2 □ Cremation 3 □ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Lorraine Park Cemetery 3/11/95 4 Donation 5 Other (Specify) _ Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 6415 Belair Road Chleen John C. Miller, Inc. Baltimore, Md. -21206 23. PART I. Entar the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line Interval Batw IMMEDIATE CAUSE (Final Onset and Death disease or condition HI reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Vza CERTIFICATION Sequantially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate Cause Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY Arrial AB 1 HYES 2 NO OF DEATH? 1 WES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TES 2 NO OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, 1erm, atreet, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homleide determined 29s. CERTIFIER
(Check only one)

2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner ea stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Belgin PERSTRAPE SIGNATURE



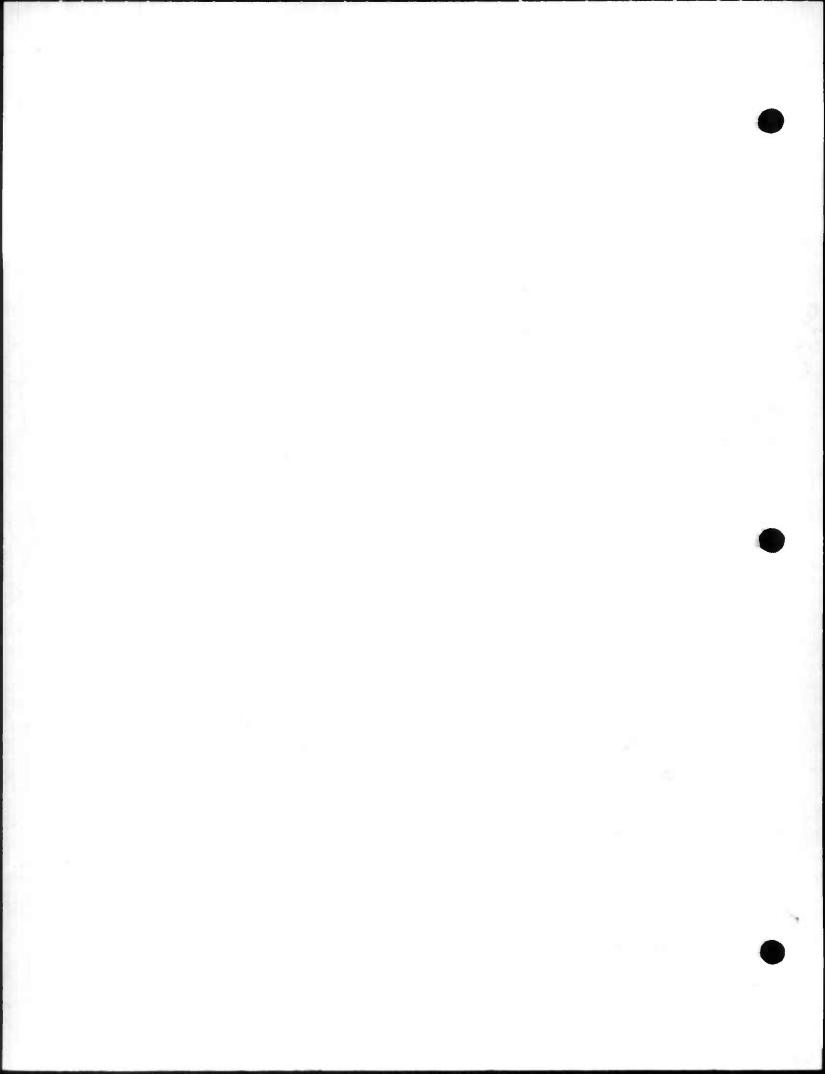
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

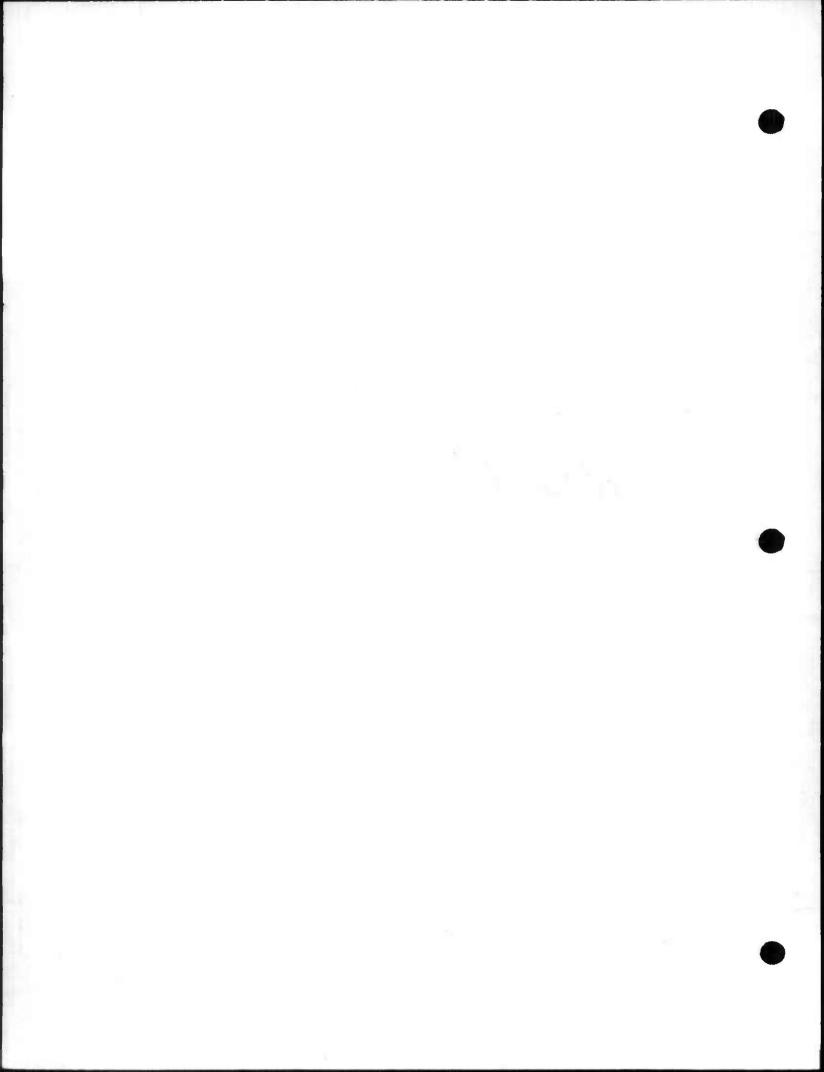
	REGISTRAR		CERTIF	ICALE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	V VE	3. TIME OF DEATH	
		YARBOROL	JGH			MARCH 5	. 1995	8:52 a*	
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)	
	214-62-9489	1 □ M 2 ¬₹	42 YRS.	MONTHS DAYS	HOURS MIN.	NOV30,19		. CAROLINA	
_	9a. FACILITY NAME (If not institution, give e	treet and number)		9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUNTY		
OB	4577 FREED	OMWAY WEST		BAL	TIMORE (n/a		
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		1 44 50-						
DIRECTOR			10e. CIT	Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS?	
	MARYLAND	n/a			TIMORE			1 YES 2 NO	
FUNERAL				10	r. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
밀	4577 FREED	OMWAY WEST			21213		UNITE		
	1 Naver Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	N U.S. ARMED	If yes, s	ecify Cuban, Mexice	IC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	or No- 14.	RACE — American Indian, Black, White, etc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	Afes	1 TYES	S 2 () NO Specify		- 1	Specify:	
	15. DECEDENT'S EDUC	CATION	18a, DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BUS	INEEC (INDICATE)	BLACK	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of a	vork done durina m	ost of working				
4	12 TH	College (Ind Ol 5+)	IAD	ORER				SHINGTON	
8	17. FATHER'S NAME (First, Middle, Last)		LAD	UNLK	16. MOTHER'S NA	ME (First, Middle, Maiden		AIRPORT	
	JESSE D.	YARBOROUGH							
BE	19e. INFORMANT'S NAME (Type/Print)	TARRESTANCE	19b. MAILING	ADDRESS (Street		TA U DU	JRROWS	rie)	
٤	LA SHAWN A.	YARBOROUGH				Y. KANSAS			
	20e. METHOD OF DISPOSITION	201	. PLACE AND DATE					or Town, State	
	1. Burial 2 Cremation 3 Remo	oval from State cen	OSHELL	her plece) MEMOR I Al	GARDEN	1			
	21. SIGNATURE OF FUNERAL SERVICE LIC	V	Vallet		ND ADDRESS OF FA	CILITY	INDALK,	, MAR YL AND	
1/	DR Well OU	2.6		WM /	МИРСИ	FH1101	E MOD	TH AVENUE	
	Osman D	mountile							
	23. PART i. Enter the diseases, or shock, or heart fellure.	complicationa that ceuse Liat only one ceuse on e	d the death. Do rech line.	ot enter the mo	ode of dying, suci	h as cardlec or respi	ratory arreat,	, Approximate interval Between	
	IMMEDIATE CAUSE (Final disease or condition	c 2	b. 00	- 1 4	21N10			Onset and Death	
	resulting in death)	(ongo)	1100 116	ac, 1	Q1N10	<u> </u>			
		C 01 11.	A CONSEQUENCE OF	" X /				2-107	
O	Sequentially list conditions,		CONSEQUENCE OF	200			271		
F	if any, leading to immediate cause. Enter UNDERLYING	111870)		7:				7215	
CERTIFICATION	CAUSE (Disease or injury that initiated events		CONSEQUENCE OF	7 :				1/1	
E	resulting in death) LAST	1		,				i I	
S		đ,							
A	PART II. Other significant condition		- 1		g ceuse given in	Part i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
EDICAL	Chlous		01/1/2	/		1 YES 2	1	COMPLETION OF CAUSE OF DEATH?	
ME	2/203 0	3 Rnea					V	1 TES 2 NO	
ż	DID TOBACCO USE CONTE	RIBUTE TO CAUSE C	F DEATH YE	S NO E	UNCERTAIN	1 121			
정	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT						
is I	1 TES 2 NO	HOSPITAL: 1 Inputient 2 ER/Out	patient 3 DOA	OTHER: 4 Nursing Hon	ne 5 Residence	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT	28d. DEŞCRIBE HOW II	JURY OCCURE	ED	
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆					
	3 Suicide 8 Could not be	28s. PLACE OF INJURY building, stc. (Spe	— At home, ferm, a	treet, factory, offic	•	28f. LOCATION (Street a City or Town, State)	nd Number or R	Bural Route Number,	
	4 Homicide determined		,,			City or lown, State)			
٦ ا	290. CERTIFIER (Check only	CIAN: To the best of my know	ledge, death occurre	d at the time, date	end place, end due	to the ceuse(a) and men	ner as stated.		
COMPLETED	one) 2 MEDICAL EXAMINE							suse(e) and menner ee stated.	
	296. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NUM				
BE	Han (Ma)	10 / mB			11905	55	> 7	GNED (MONTH, Day, 1881)	
임	30, NAME AND ADDRESS OF PERSON WH		ATH (ITEM 27) (Type.	Print	0,71	0 1:	7	1111	
	(car / 1/18)	10.	4940	Facto	in Avo	Relt	m.) n 1724	
	31. DATE FILED (Month, Day, Year)	-1-1	ATURE	١١ ١٠٠٠	01	7 .7 W.	. 0	1212-1	
	MAR 1 0 1995 4	32. BEGISTRAR'S SIGN	dall					J	
	111111111111111111111111111111111111111								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

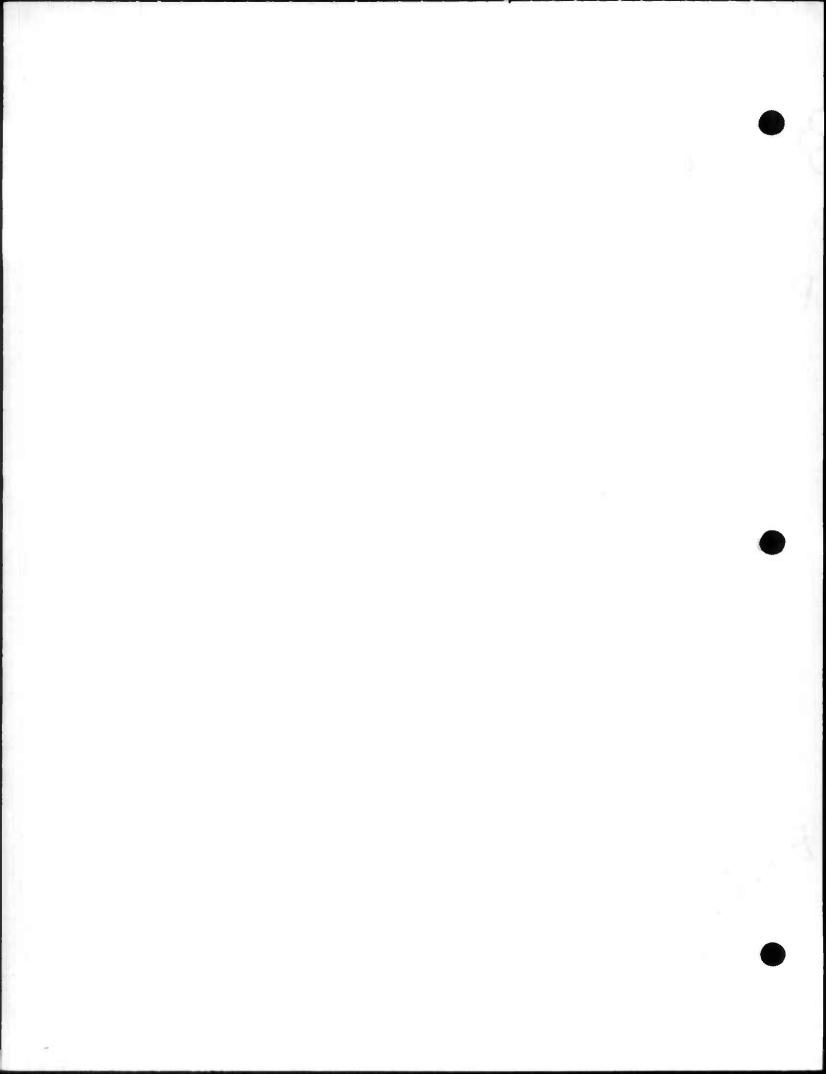
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The	TO THE FUNERAL DIRECTOR: After this certificate it	be filed within 72 hours after death with the State	IMPORTANT: If item 28 is marked, or item	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF H	EALTH AND	MENTAL HYGIEN						
1)	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	EMALEA ELIZABETH	YOUNG				MARCH 7	199	7:48 a M				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 1 UNDER 1 YEAR 1 UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 Mar. 3, 1933 1 Mass											
	231–36–9267 9a. FACILITY NAME (If not institution, give str	Massachusetts										
Œ	Malana G											
100	RESIDENCE OF DECEDENT											
DIRECTOR	NV 10b. COUNTY Clar	k		Y, TOWH OR LOCAT				10d. INSIDE CITY LIMITS?				
	11.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.											
FUNERAL	1117 Purple Mar	tin Court		101	89031		USA	N OF WHAT COUNTRY?				
5	11. MARITAL STATUS	12 WAS DECEDENT EVED IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye		. RACE — American Indian.				
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO ATES	If yes, sp	ecify Cuban, Maxica 2 NO Specif	in, Puerto Rican, atc.)		Specify: White				
ETE	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of v life. Do NOT us	vork done durina mo	N st of working	18b. KIND OF BU	ISINESS/INDUS	TRY				
PL	12 Companion Health Care											
COMPLETED												
BE	Doseph C. Welch Emma MacDonald											
2												
	20a. METHOD OF DISPOSITION		.PLACE AND DATE (
	1 Burial XXCremation 3 Remo	val from State	etery cremetory or of etro Cr	her place) remator	V	DATE 20c. LOCATION — City or Town, Stata 3/8 Baltimore, MD						
	21. SIGNATURE OF PHYERAL SERVICE LICE			22. NAME AN	ID ADDRESS OF FA	CILITY						
	Datel 1) W	MI				neral Hon						
	23. PART I. Enter the diseases, Dr Ct	omplications that caused	the death. Do n	ot enter the mo	de of dying, suc	h ss csrdiac or reap	iratory srres	t, Approximate				
1	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fins) disease or condition											
	disease or condition regulting in death) a. BRAIN STEN CEREBROVASCOLAR ACCIDENT											
	DUE TO (OR AS A CONSEQUENCE OF):											
NO.	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	7):								
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury							!				
트	that initisted events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	d.	•										
AL.	PART ii. Other eignificent conditions	contributing to death b	ut not reauiting i	n the underlying	ceuse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS				
MEDIC						1 YES :	-	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
ME								1 TYES 2 NO				
PHYSICIAN:	DID TOBACCO USE CONTR				UNCERTAI	V 🗆						
S		HOSPITAL:	28. PLACE OF DEAT	OTHER:								
НХЗ	27. MANNER OF DEATH	1 N Inpetient 2 ER/Outp. 28a. DATE OF INJURY	28b. TIM	OF 28c. INJ	JRY AT	6 Other (Specify) 26d. DESCRIBE HOW	NJURY OCCUP	IED .				
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	URY WO	RK? ES 2 NO							
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, s	treet, factory, office	,	281. LOCATION (Street City or Town, State		Rural Route Number,				
4 Homicide determined												
COMPLETED	(5115011511) 22	IAN: To the best of my knowl										
00	2 MEDICAL EXAMINER	: On the basis of examination	and/or Investigation	n, in my opinion, de	ath occured at the	time, data and place, at	nd due to the c	suse(a) and manner as stated.				
BE	296. SIGNATURE AND TITLE OF CERTIFIER	11/=	140		29c. LICENSE NUI	ABER	29d. DATE SI	GNED (Month, Day, Year)				
5	30, NAME AND ADDRESS OF PERSON WILL	COMPLETED CAUSE OF DE	TH STEN OF ST	DAME COT	NY 167	7273-1	7 1	MARCH 95				
	30. NAME AND ADDRESS OF PERSON WHO RONALD S WAT		nin (IIEM 27) (1/pe,									
		15, MAJ, MC	fugg.	ANDREWS	AFB MD	20331-66	30					
	MAR 1 0 1995	UL DIMUNESCI POR		-								



FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE O	F DEATH

_		1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE OF DEATH	<u>.</u>		3. TIME OF DEATN
		Joseph			Yokub	inas					MONTH	, 199	YEAR	3:00 A. M
		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. Is		IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	, 199		PLACE (State or Foreign
		203-01-085	0	1 💢 M 2 🗆 F	83	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) July 16,	1011	Country	sylvania
3 should		9a. FACILITY NAME (If not in	nstitution, give s	freet and number)			9b. CITY	, TOWN	OR LOCATE	ON OF DE			NTY OF O	
2, 3 \$	l H	9512 Perry	Hall	Blvd., A	pt. 201				Balti				altir	
	DIRECTOR	RESIDENCE OF DEC											4761	
Page	=		10b. COUNT			10c. CIT	Y, TOWN							10d. INSIDE CITY LIMITS?
permit. Pages		Maryland 100. STREET AND NUMBER		1timore					timo					1 YES 2 XNO
it.	FUNERAL	9512 Perry		R1vd A	n+ 201			10	H. ZIP COD					HAT COUNTRY?
020 physician. burial-transit	=	11. MARITAL STATUS	Hall	12. WAS DECEDEN		PMEO	140	WW 0 05		1236			U.S.A	
D20 physic burfal		1 Never Married 2 X	Married	FORCES? 1	MAR OR DATES	NO		if yes, sp	pecify Cubi	in, Maxica	NC ORIGIN? (Specify Y	es or No—	Black	- American Indian, White, etc.
\$ 1 P	Æ	3 Wildowed 4 Dive	orced	IF TES, GIVE V	MAR OR DATES			1 U YES	2 X NO	Specify	τ.	- 4	Specif	White
r attend	COMPLETED	15. DEC	EDENT'S EDU	CATION completed)	18a, D	ECEDENT'S	USUAL O	CCUPATIO	ON ost of workli		16b. KIND OF B	USINESS/INC	USTRY	
	19	Elementary/Secondary (I		College (1-4 or 5	+)	o. Do NOT u	se retired.)		OSE OF WORKI	10				
AND the hospital detached to	M P	8th grade				Carpe	nter				Cons	truct	ion	
/LAND by the hospit be detached	COM	17. FATNER'S NAME (First, M									ME (First, Middle, Maide			
RAY Be by be by be by be by be by by by by by by by by by by by by by	BE (Thomas Jokubynas Catherine Ramanauskas 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
MARYLAND retained by the hospit 5 should be detached	TO B	19a. INFORMANT'S NAME (TyperPrint) Harriet Yokubinas (wife) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 9512 Perry Hall Blvd., Apt. 201, Balt., MD 21236												
	9	20g, METHOD OF DISPOSIT		s (wire)						Ivd.				
BALTIMORE, er death. Page 6 may be the funeral director, page val.	1031 00	1 X Burial 2 Crematic	n 3 🗆 Rem	oval from Stala	20b. PLACE cemetery, cr Garde	ematory or o	ther place)	ition/N∈ t + Ъ	Como:	+ ~ ***	3 /8 D	OCATION —		,
ALTIM death. Page funeral dire		21. SIGNATURE OF FUNERA		ENSEE	Garde	113 0			ND ADDRE			LLTMO	re, M	aryland
death. Page tuneral dir		10/1	Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236											
0 = 0		1 PART I STATE OF	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.											
hours after of in by th or remova		shock, or h	aert fallure.	List only one ceu	use on each line	90(11. DO 1	not anter	the mo	or ay	ing, suci	n as cardiac or res	oiratory arr	est,	Approximate interval Between
24 E		IMMEDIATE CAUSE (Fir disease or condition	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Progressive resultant 312 tirelis											
ted within 24 completely filler al, cremation,		BUE TO (OR AS A CONSEQUENCE OF)												
N 5 - 6			_	Uver		OUENCE U	(1						
OX 68: e be execute sician and confor to buria	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
BOX cate be ex thysician a	CA	cause. Enter UNDERLYING CAUSE (Disease or injury												
P.O. B th certificati andling physical Hygiene p	THE	that initieted events resulting in deeth) LAS		DUE TO	(OR AS A CONSE	OUENCE O	F):							
_ = = =	5 15	resulting in deeth) LAS		đ										
DS, F the death the atter d Mental		PART II. Other algolfice	nt condition	a contributing to	deeth but not	not resulting in the underlying ceuse given in Per				Pert I. 24a. WAS A	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS	
CORDS, res that the dea igned by the att ealth and Menta	DICAL		raly	orten	, dise	ANS	L				PERFO	RMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE
O 등 등 등 1	MED									-	1 TYES	2 NO		OF DEATH?
W requ		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	TH Y	S.D.	NO K	I/INC	FPTAIN				1 - YES 2 NO
Se as	SICIAN:	25. WAS CASE REFERRED TO				E OF OEA				LICIAII				
SICIAN: The certificate h the State [SIC	EXAMINER?		HOSPITAL:	ER/Outpatient	□ DOA	OTHER		ne 5 Re	sidence	8 Other (Specify)			
OF VI PHYSICIAN: this certifica with the Str	. 7	27. MANNER OF OEATN		26a. DATE OF (Month, D	INJURY	28b. TIM	E OF	28c. INJ	_/	I	28d. DEŞCRIBE NOW	INJURY OCC	CURED	
NG PHYS frer this cath with	ВУ		Pending Investigation	[M		YES 2	NO				
R: Aff	2 0	3 Suicide 8	Could not be	28s. PLACE O building,	F INJURY — At he atc. (Specify)	me, larm,	atreet, lect	ory, offic			281. LOCATION (Street City or Town, State	and Number	or Rural Ro	oute Number,
OR ATTENDING OR ATTENDING OF ATTENDING THE PROME AFTER DEATH 28 15 man		4 Homicide	determined								ony or rown, oran	,		
L OIREC	البداا	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	eth occum	ed at the ti	me, data	and place,	and due	to the cause(s) and m	nner as atet	ed.	
HOSPITAL FUNERAL within P	Ö													and manner as stated.
HE HO BE FU	BE	290 ONG MATURE AND FILE	OF CENTIFIE	1	/				29c. LICE	NSE NUM	BER	29d. DATE	E SIGNED	Mongo, Day, Year)
TO THE HOSPITAL TO THE FUNERAL DE filed within-PPP	TO B	Muly	_	ren o	/				22	133	9	171	100	271995
	F	38. NAME AND ADDRESS OF												
		Dr. Linda F				Rd.,	Be1	Aiı	r, Ma	ryla	nd 21015			
_		31. DATE FILED (Month, Day.		32. REGISTRA	R'S SIGNATURE									
		MAR 1 0 1	333	ma william	THE PERSON NAMED IN									_



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

	REGISTRAR		CE	RTIFI	CATE C	F DEATH		REG. NO.					
	DECEDENT'S NAME (First, Middle, Linst)	Norma Virg	inia Z	Zemar	el		2. DATE OF MONTH March	DEATH D		YEAR	3. TIME OF DEATH		
H.	4. SOCIAL SECURITY NUMBER 214-12-4520	1 □ M 2××F	GE (In yrs. last i		IF UNDER 1 YEA		7. DATE OF (Month, D	BURTH		Countr	PLACE (State or Foreign y)		
ron	98. FACILITY NAME (If not institution, give str Stella Maris Hos					IN OR LOCATION OF D	DEATH			NTY OF D	EATH		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Marked and			10c. CITY,	TOWN OR LO						10d. INSIDE CITY LIMITS?		
	Maryland Balti 100. STREET AND NUMBER	more		Towson					10g. CITIZEN OF WI				
FUNERAL	2300 Dulaney					J.S.A							
B≼	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YES, GIVE WAR O	ES 2 NO	ED)	If yes	DECENDENT OF HISPA , specify Cuben, Maxic /ES 2 NO Speci	an, Puarto Rica	ipecity Yea n, atc.)	or No—	14. RACE Black Specif	- American Indian, White, atc. y: White		
TED	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	(G/ve	EDENT'S Use kind of we	ISUAL OCCUP	ATION most of working	16b, Kil	OF BUS	INESS/IND	USTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		mema				Own I	Home				
BE CO	17. FATHER'S NAME (First, Middle, Lest) Frank E. B	eck				16. MOTHER'S NA	AME (First, Midd ley	Byri					
10	19a. INFORMANT'S NAME (Type/Print) Emil F. Zemarel		19b.	Sam	ADDRESS (Street	et and Number or Rural	Route Number,	City or Town	n, State, Zip	Code)			
	20a, METHOD OF DISPOSITION 1 \(\times \) Burial 2 \(\times \) Cremation 3 \(\times \) Ramo 4 \(\times \) Donation 6 \(\times \) Other (Specify)	val from State	206. PLACE AN cometery, cremi Dulane	etory or oth	er nlene)		DATE 20c. LOCATION — City or Town, State S. 13-4-95 Timonium. Maryland						
	Dulaney Valley Mem. Gards. 3-4-95 Timonium, Mary 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204												
	23 PAPT I. Enter the diseases, or contained the shock, or heart failure. LIMMEDIATE CAUSE (Final disease or condition	lat only one cause of	n each line.		ot enter the	mode of dying, suc	ch ea cardlec	or reapl	ratory arr	eat,	Approximata interval Batween Onset and Death		
z	resulting in death)	DUE TO (OR A	Leles	IENCE OF)	~ (1	alopate	<u> </u>				2 who		
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c										5 42		
CERTIFICATION	that initiated eventa resulting in death) LAST			A CONSEQUENCE OF: furtary ferrer (berng)							590		
EDICAL C	PART II. Other algnificant conditions	contributing to deat	h but not rea	ulting in	the underly	ring ceuse given in		PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
W	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATI	H YES	. □ NO	□ UNCERTAI	_		7-0		OF DEATH? 1 YES 2 NO		
SICIAN	25. WAS CASE REFERRED TO MEDICAL	HOSPITAL:		OF DEATH	Check only o								
PHYS	1 VES 2 VA NO 27. MANNER OF DEATH	1 Inpetiant 2 ER/C		DOA 28b. TIME	Mursing H	ome 5 Rasidenca	6 Other (Sp		HIBY OCC	HIBED			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yes	nr)	INJU	RY	WORK? YES 2 NO	Zod. DESOM	DE HOW II	15011 000	ONED			
ETED I	3 Suicide 6 Could not be determined	28e. PLACE OF INJU building, etc. (S	JRY — At home Specify)	e, farm, str	reet, factory, o	ffice	26f. LOCATIO City or To	N (Street a wn, State)	nd Number	or Rurel R	oute Number,		
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINER	IAN: To the best of my kr									and manner as stated.		
BE C	240. SIGNATURE AND TITLE OF CERTIFIER	eenla				29c. LICENSE NU	MBER				(Month, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM :	27) (Type, F	Print)	,	2590		•	3/2	-195		
	James Quinler 31. DATE FILED (Month, Day, (bar)			ck Ro	ad, Ba	altimore,	Maryla	ınd					
	MAR 1 0 1995 July	2. REGISTRAR S	Lil										

F VI AL AECOADS, F.O. BOX 88760, BALLIMORE, MARYLAND 21215-0020	TO THE MOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Extraours after death. Page 6 may be retained by the hospital or attending physician.	OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should fer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attendibe filed within 72 hours after death with the State Dept. of Health and Mental Hy	IMPORTANT: If item 28 Is marked, or item 23 shows any injury, or

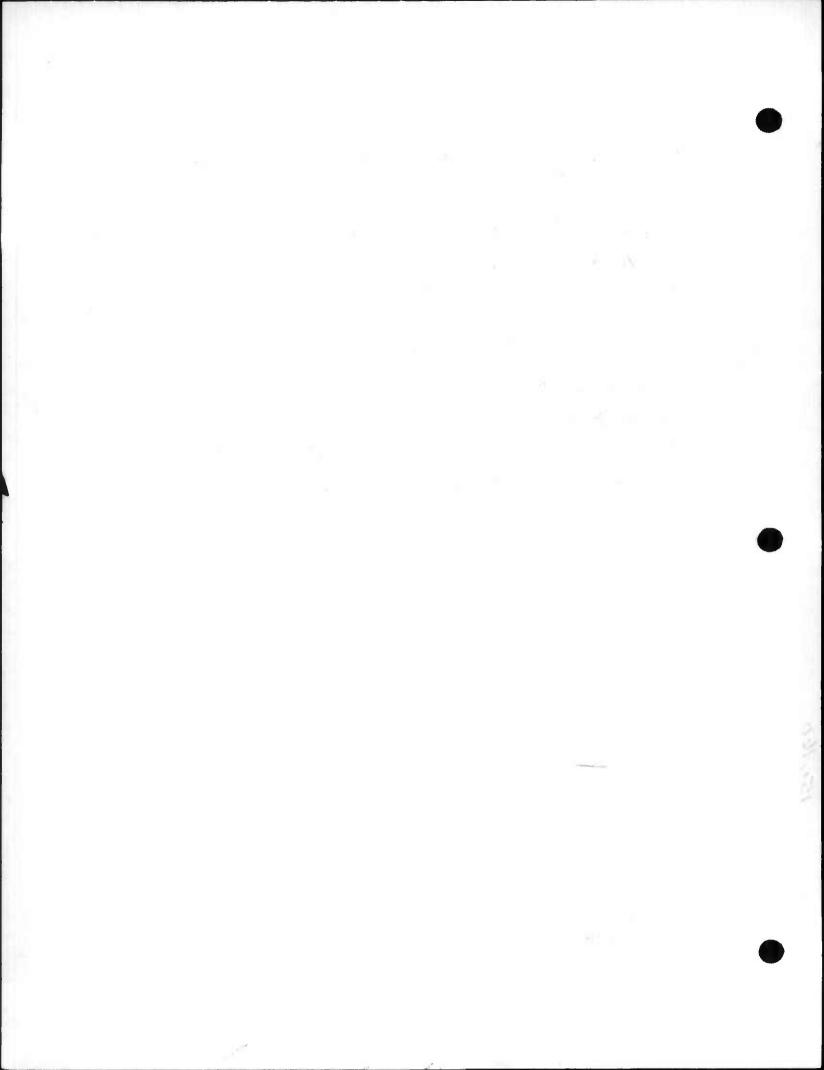
	FOR STATE	OF MARYI AI	NN / NEPAR	TMENT OF	HEALTH AND	MENTAL L	WAITHE		, 0 2 0		
	1 - STATE REGISTRAR	01 19171111 1241	CERTIF	ICATE OF	DEATH		EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF			TIME OF DEATH		
	Martin Luther Alban,					монтн 3	12 1	995	9:20 a m		
	4. SOCIAL SECURITY NUMBER 5. SEX 1 (X M 2	□F 63	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E	, 1931	8. BIRTHPLA Country) Mar	ryland		
OR	9. FACILITY NAME (If not institution, give street and num 3725 Maple Grove Rd.	iber)			OR LOCATION OF DI		9c. COUI	TY OF DEATH			
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY										
- DIRECTOR	Maryland Carroll		10c. CIT	Manches					d. INSIDE CITY LIMITS? YES 2 NO		
AAL	10e. STREET AND NUMBER			10	f. ZIP CODE			ZEN OF WHAT	COUNTRY?		
FUNERAL	3725 Maple Grove Rd.	·			21102			S.A.			
B	1 Never Merried 2 X Merried FORCE	ECEDENT EVER IN U S? 1 TYES GIVE WAR OR DATE	2 40	If yes, sp	CENDENT OF HISPAN Becify Cuben, Mexica 3 2 NO Specify	n, Puerto Rican	pecify Yee or No-	Black, WI Specify:	American Indian, hite, etc.		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	ON ost of working	16b. KIN	D OF BUSINESS/IND							
COMPLETED	Elementary/Secondary (0-12) College (1		life. Do NOT us	Operato		Bl	ack & De	cker			
Ö	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	ME (First, Middle	, Maiden Surname)				
BE	Earl A. Alban					Marti					
10	190. INFORMANT'S NAME (Type/Print) Carmen Louise Alban		3725	ADDRESS (Street of Maple Gr	nd Number or Rural I	Number, C Manche	ity or Town, State, Zip	Code) • 2110)2		
	20e METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)	206. PL	20b. PLACE AND DATE OF DISPOSITION (Name of			DATE	20c. LOCATION — C	Cify or Town,	State		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	. 1			ND ADDRESS OF FA	CILITY		- 0,			
9	. J. South Est	0000		3296	dt Funer harmil D	r. Man	chester.	MD. 2	21102		
	23. PART I. Enter the diseases, or complication abook, or heart feiture. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death)	ns that caused the cause on each	n lina.			or reapiretory arre	eat,	Approximate interval Between Onset and Daath			
	resolding in death)	DUE TO (OR AS A CO	ONSEQUENCE OF):					6 405		
CERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CO									
빙	d										
MEDICAL	PART II. Other significant conditions contribut	ing to death but	not resulting i	n tha undarlyin	g cause given in		WAS AN AUTOPSY PERFORMED? YES 2 NO	OF E	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO		
PHYSICIAN:											
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL OTHER:	ACE OF DEATH (Che	ck only one)					
≥ E		nt 2 ER/Outpetle		4 - Nursing Hom	5 Presidence						
BY P	1 Netural 5 Pending 2 Accident Investigation	ATE OF INJURY lonth, Day, Year)	20b. TIME	M 1 1	RK? /ES 2 NO	28d. DESCRIB	E HOW INJURY OCC	URED			
	3 Suicide 8 Could not be determined	ACE OF INJURY — illding, etc. (Specify)	At home, term, a	treet, factory, office		28t. LOCATION City or Tow	(Street and Number on, State)	or Rural Route	Number,		
COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the 2 MEDICAL EXAMINER: On the back	best of my knowledg	je, death occurre	d at the time, date	end place, and due	to the cause(e)	end manner se state	d.			
_	295, SIGNATURE AND TITLE OF CERTIFIER										
N N	WWW Alinda	100			29c. LICENSE NUM	I G LL	29d. DATE	SIGNED (Mon			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	-	_	2	110071	674-1	796	VCh 13	,1995		
			ORGE	71.	HAUN	a I	UA				
100	31. DATE FILED (Month, Day, Year) MAR 1 3 1995 July Drubler Randly										

I I H-I--· _ . . .

ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/17/95 t.t

95 07527

		FOR STATE REGISTRAR	TATE OF MARYLAN	D / DEPAR	TMENT OF I	HEALTH AND		HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF MONTH	DEATH	ZEAR 3. TIM	E OF DEAT	Ή
		SAVANNAH 4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In vr	s. last birthday)	ALLAF		MARCI			40	Ам
Should			M 2 XF	YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF (Month, De	16,1994	BIRTHPLACE Couptry) JASH	State or Fo	reign
1, 2, 3 SR	стов	LAUREL REGIONAL			LAURE	OR LOCATION OF DI	EATH	PRIN	Y OF DEATH NCE GI	EORG	ES
200	DIRE	10e. STATE 10b. COUNTY	G. Co.	10c. CIT	LAUR				L U	ISIDE CITY IMITS?	
ansu permit.	FUNERAL	10e. STREET AND NUMBER	Riv6Hous	E L	TNE 10	20708		10g. CITIZE	SA.	DUNTRY?	1
as the bullat-trailist	B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO	If yes, sp	CENDENT OF HISPAI Decify Cuben, Mexico 3 2 NO Specif	m, Puarto Rica	pecify Yea or No — 14 n, etc.)	Black, White,	etc.	ın,
	LETED	15. DECEDENT'S EDUCATIK (Specify only highest grade com Elementary/Secgndary (0-12)	0N 16a pleted) 16a	OBCEDENT'S (Give kind of ville. Do NOT us NEVE		ON ost of working	16b. KIN	ID OF BUSINESS/INDUS	_		
at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	1/0/0	MELE	r wo		ME (First, Midd	le, Malden Surname)	4		
notified	TO BE	190. INFORMANT'S NAME (Type/Print) ALLAN T. ALLAN	h	19b. MAILING		and Number or Rural		City or Town, State, Zip Co	ode)	207	18
Pe		20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal			F DISPOSITION (N		DATE	20c. LOCATION — CH	y or Town, Stel	· U	
ar must		4 Donation 5 Other (Specify)	57	Crema Cos	EPH CE	M. 3-	10-95	MONR	DE, H	11	
ехашиви		21. SIGNATURE OF FUNERAL SERVICE INCENS	Skarle	7 -	SKA-A	DA FH	. 25	34 LTO., 1	4D. 2	172	4
event, the medical		23. PART I. Enter the diseases, or companions, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	SUDDEN INFANT DUE TO (OR AS A CO)	DEATH S	YNDROME	ode of dying, auc	h aa cardiac	or respiratory arrea	ir	ipproxima nterval Be Inset and	tween
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
	EDICAL C	PART II. Other algnificant conditions co	ntributing to deeth but n	ot resulting i	n the underlyin	g ceuse given in		NAS AN AUTOPSY PERFORMED? YES 2 NO	COMPLI	ETION OF C	то
2	IAN: MED	DID TOBACCO USE CONTRIBU	JTE TO CAUSE OF D	EATH YE	S NO	UNCERTAIN		S LES S NO	DF DEA	TH? ES 2 □ N	10
Eem	SICIA		SPITAL:		H (Check only one) OTHER:						
6	PHYS	1XIXES 2 □ NO 1 □ 27. MANNER OF DEATH	Inpatient 2 X ER/Outpatien 26e. DATE OF INJURY	28b. TIME	OF 28c, INJ	BURY AT		ecity) BE HOW INJURY OCCUP	IED.		-
	BY P	1) Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	JRY WC	PRK? YES 2 NO	200. 02.001111	DE HON MOON OCCUP			
		3 Suicide 8 Could not be determined	26a. PLACE OF INJURY — A building, atc. (Specify)	it home, ferm, s	reet, fectory, offic	•	28f. LOCATIO City or To	N (Street end Number or wn, State)	Rural Route Nur	mber,	
I. II REIII	OMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN 2 X MEDICAL EXAMINER: Or							ause(e) end ma	nner ee str	ated.
POR	BE CO	SIGNATURE AND TITLE OF CERTIFIER) (29c. LICENSE NUM	ABER	29d. DATE S	IGNED (Month,	Day, Year)	
=	۵	30. NAME AND ADDRESS OF PERSON WHO CO	1 4								<i>y</i>
		31. DATE FILED (Month, Day, Year)	32/THEGISTRAR'S PONATUR JEUGUECK ROMATUR		ENN STE	REET BAI	LTIMO	RE MARYLA	AND 2	1201	
		MAD 1 2 1005	discountry range	ц							



be notified at once.

DRE, MARYLAND 21215-0020

1	-	FOR STATE REGISTRAR	
1	0	ECEDENT'S NAME (First	6 Aledello

STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		C	ERTIF	ICATE OF	DEAT	Н	REG. N	IO.		
	1. DECEDENT'S NAME (First, Middle, Last)	BRING	- Ruth	Fleio	Brinck			2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH
	100111 01310						- /	MAnch	10 1	995	130 M
		5. SEX 8.	. AGE (In yrs. Ia:	st birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 2	MIN.	7. DATE OF BIRTH (Month, Day, Year)	1921	Country	PLACE (State or Foreign yland
	9e. FACILITY NAME (If not institution, give stre	eet and number)									-
oc						IH		UNTY OF DE			
2	Fallston Genera	II Hospi	tal		ral	lsto	n		1 1	Harf	ord
ည	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY										
FUNERAL DIRECTOR		Harford		10c. CIT	Y, TOWN OR LOCA	Street					10d. INSIDE CITY LIMITS? 1 YES 2 NO
4	10e. STREET AND NUMBER				1						NAT COUNTRY?
IER/	307 Cherry Hill	Road				21154					A
5	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1	VER IN U.S. AF	RMED	13. WAS DE	CENDENT OF	HISPANIC	ORIGIN? (Specify	fee or No-	14. RACE	- American Indian, White, atc.
7	4	IF YES, GIVE WAR	OR DATES	NU		pecify Cuben, S 2 XNO		Puerto Rican, etc.)		Specif	
В	3 Widowed 4 Divorced					Can.	.,,.			opacii,	White
유	15. DECEDENT'S EDUCA	ATION	16a. DE	CEDENT'S	USUAL OCCUPAT	ION		16b, KIND OF E	USINESS/IN	DUSTRY	WIII CC
	(Specify only highest grade of Elementary/Secondary (0-12)		(G	ive kind of w Do NOT us	vork done during n e retired.)	ost of working		=======================================			
7	12	College (1-4 or 5+)		Rug	Driver			Coh	1 -	D	
2	17. FATHER'S NAME (First, Middle, Last)			Dus	priver	_				trans	sportation
COMPLETED								E (First, Middle, Maid	,		
BE	Johannes	"unknow	<u>n" F</u>	isch	er	Ca	athe	rine	'unkı	lown'	" Berk
	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Street	end Number o	r Rural Rou	ute Number, City or T	own, State, Z	ip Code)	
임	Mr. Arthur M. B	rinck	3	07 C	herry	Hi11	Rd.	Stre	at 1	an a	21154
W.					F DISPOSITION (A		nu.		OCATION -		
	20e. METHOD OF DISPOSITION 1	ral from State	cemetery, cre	metory or ot	her place)	ame of	00/1	DATE 20c.	LOCATION -	· City or Tov	vn, State
V I	4 Donation 5 Dother (Specify)		Metro	Cre	matory,	inc.	03/1	1/95	Balti	Lmore	e, MD
)	21. SIGNATURE OF SUNERAL SERVICE LICENSEE MALL 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc.										
	Coores	MacNabb	1		Orem	attor	1 20	ciera	OT MC	1.,	inc.
	George E.				299	Frede	eric	k Road	Balt	.0.,	MD 21228
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between										
	IMMEDIATE CAUSE (Finel										
	diseese or condition	Mulli	2 210	1868	7:20						i
	resulting in death) a.	MU/+	R AS A CONSE	DIJENCE OF	0:						10 years
_		202 10 (0.	THO A CONSE	WOENCE OF	J -						
CERTIFICATION	Sequentially list conditions, b.	0115 70 101									
5	if any, leading to immediate	DOE 10 (0)	AS A CONSE	DUENCE OF):						
0	CAUSE (Disease or injury										
=	that initiated events	DUE TO (OF	AS A CONSE	QUENCE OF):						
1	reaulting in deeth) LAST										
EDICAL	PART II. Other significent conditions		eth but not i	esulting i	n the underlyir	g ceuse glv	ven in Pa	ert i. 24a. WAS /	N AUTOPSY		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
5	(Ecent Vauseps;	5 3 we	che					_ 1 _ YES	- /		COMPLETION DF CAUSE
			*****					_ ' ' ' ' '	- 100	- 1	OF DEATH?
Σ	DID TORACCO LISE CONTROL	DLITE TO CALL	TE OF DE A	TII 3/-	C [] 110 [7 1010	m=4.55.0	-1			1 NES 2 NO
Z	DID TOBACCO USE CONTRI	BUIE 10 CAUS					RTAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	E DF DEAT	H (Check only one	}					
S		1 Inpatient 2 E	R/Outpatient 3	□ DOA	OTHER: 4 Nursing Hor	ne 5 🗆 Reel	dence 8	Other (Specify)			
ξI	27. MANNER OF DEATH	28e. DATE OF IN.		28b. TIME	OF 28c. IN	JURY AT	7	ed. DESCRIBE HOW	/ INJURY OC	CURED	
	Natural 5 Pending	(Month, Day,	reer)	INJU		ORK? YES 2 -	NO				
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF IN	JURY — At ho	me form e			-	81. LOCATION (Street	A conditions		
	8 Could not be	building, etc.	. (Specify)	,	meet, tectory, orm	.4	ľ	City or Town, Sta		r or nunei no	oute number,
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my	knowledge, de	eth occurre	d at the time, dat	end place, e	and due to	the cause(e) and m	enner as at	ited.	
2	one) 2 MEDICAL EXAMINER:										and manner as stated
8					, opinion,					re vense(s)	
шШ	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
80	Drust S. T	·	mp			0.3	322	99	N	PARCH	10,1995
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type,	Print)	- 0				, , ,,,,	, 511,13
	David S. DUNN		BELAIR	- 4	Re	1 1.	4. 1	nd. 210	111		
	The state of the s	32 ded stp.	SIGNATION	B 40	200	1 F 17	10 1	14,216	117		
	31. DATE FILEDWARPON 1993 1995	71000 201	OR CHARL	ertall							

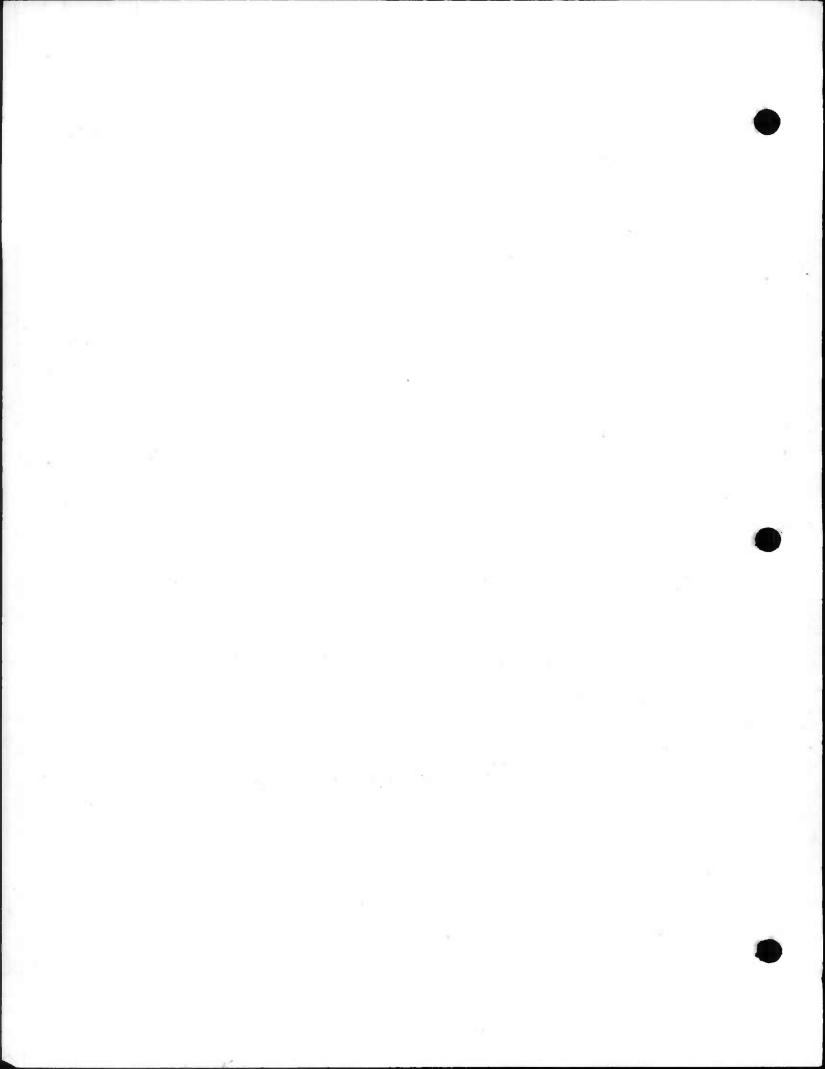
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings from a flat death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
HOSPITAL OR ATTEND	FUNERAL DIRECTOR: , within 72 hours after o	TANT: If Item 28 Is
TO THE	TO THE be filed	IMPOR

1, 2, 3 should

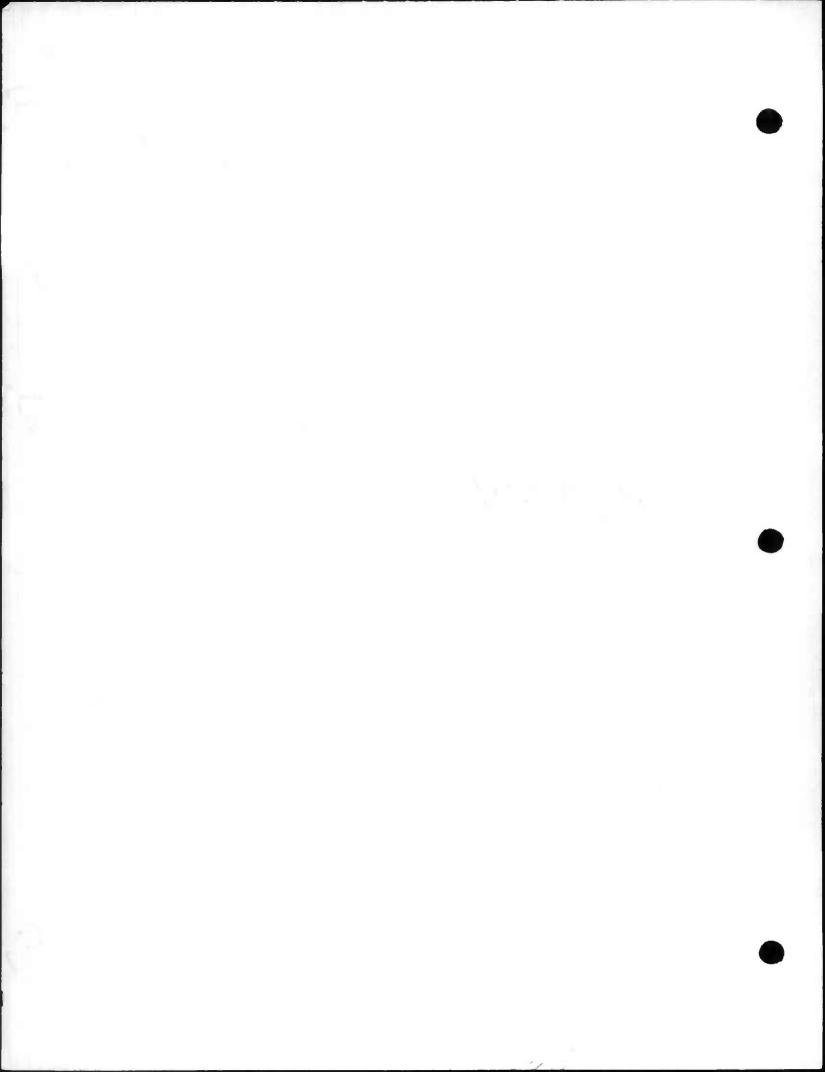
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
9	1. DECEDENT'S NAME (First, Middle, Last)	0				2. DATE OF DEATH		3. TIME OF DEATH		
	Catherine	Byrd				1 -	DAY YEAR 95	0700 AM		
		/	rs. lest birthday) IF UND	ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign		
1	0.00 30 1001	1 □ M 2 □ F	62 YRS.		HOURS MIN.	07-13-39		TIMORE,MD.		
æ	9e. FACILITY NAME (If not institution, give street				R LOCATION OF DE		9c. COUNTY OF			
DIRECTOR	REGENCEY NURSING HOME FORESTVILLE, MARYLAND PRINCE GEORGE, CO.									
REC	10e. STATE 10b. COUNTY		10c. CITY, TOWN					10d. INSIDE CITY LIMITS?		
		GEORGE,CO.	TEMPLE		, MARYLA	ND		1 🕅 YES 2 🗌 NO		
FUNERAL	100. STREET AND NUMBER TEMPLE 2617 SOUTHERN AVEN	HILL,MD. NUE APT.#38		10f.	ZIP CODE	4.0		WHAT COUNTRY?		
NE NE		2. WAS DECEDENT EVER IN U.S	S. ARMED 19	WAS DECI	207	48 C ORIGIN? (Specify Ye	U.S.A.	E — American Indien,		
YFI	1 Never Married 2 Merried	FORCES? 1 YES 2	. ⊠NO	If yes, spe	city Cuben, Mexican 2 NO Specify:	, Puerto Rican, etc.)	Blac Spe	ck, White, etc.		
) BY	3 Widowed 4 Divorced							AMERICAN		
TEC	15. DECEDENT'S EDUCAT (Specify only highest grade co	*ION 16/mpleted)	e. DECEDENT'S USUAL. (Give kind of work don life. Do NOT use retired.	e durina mas	N at of working		JSINESS/INDUSTRY			
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	CUSTODIAN	,		COON &	MONTGOME	RY REALESTATE		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	IE (First, Middle, Meider	Sumama)			
BE C	WILLIAM SAUNDERS				FRANCES		, carranto,			
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRE	SS (Street ar		oute Number, City or Tox	wn, State, Zip Code)			
-	WILLIAM BYRD					APT.B3 TE	MPLE MARY	YLAND 20748		
20e. METHOD OF DISPOSITION 1XJ Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE of DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION — City or Town								own, State		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE WAS CONSIDER 225.20 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY 24. SIGNATURE OF FUNERAL SERVICE LICENSEE 25. NAME AND ADDRESS OF FACILITY 26. NAME AND ADDRESS OF FACILITY 27. NAME AND ADDRESS OF FACILITY 28. NAME AND ADDRESS OF FACILITY 29. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE									
	155	A racaract	DUAL P	20:	53 James 9	nocken but	woif			
	22 DADT I Delay the discourse of any	fel	PE	etun	eral Home de	a Arresto	englla.	22.485		
	23. PART i. Enfer the diseeses, or con shock, or heart feliure. Lis	it only one cause on sech	ilne.	er tha mod	le of dying, such	as cardiac or resp	piratory arrest,	Approximata intarvai Between		
	IMMEDIATE CAUSE (Final disease or condition									
	resulting in death) e	OUE TO (OR AS A CO	NSEQUENCE OF):	e ra	126 11.	1 after	71100	2-5mm5		
z	- Under hine Common Arterio Dis case									
AT 10	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEQUENCE OF:	-0	1 9.	< 4		make		
FIC.	CAUSE (Diseese or injury	DUE TO (OR AS A CO	TEVING L	- CM	duction	1 John		10.41		
CERTIFICATION	that initiated events resulting in death) LAST		mandation of p			73				
	DART II ON W									
SAL	PART ii. Other significent conditions of	L'Eavure,	not resulting in the u		cause given in P	Part I. 24e. WAS AP PERFO		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDICA	21.11	. /4 /	Cagrexi	(a) -	7/2-	1 YES	2 NO	COMPLETION OF CAUSE OF DEATH?		
Σ	DID TOBACCO USE CONTRIE	CHITE TO CALLES OF P	METERSIUS	es No 🗔	III ICEDTAIN			1 TYES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (Check		UNCERTAIN					
Sic		IOSPITAL:	ОТНЕ	R:	5 Residence 6	Other (Specific)				
并	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJU	RY AT	28d. DESCRIBE HOW	INJURY OCCUREO			
BY	1 Natural 5 Pending 2 Accident Investigation	(MOINI, Day, 16al)	INJURY	1 Y	The same of the sa					
1	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — A building, atc. (Specify)	At home, ferm, street, fa-	ctory, office		28f. LOCATION (Street City or Town, State	end Number or Rural	Route Number,		
Ë,				- :						
COMPLETED		N: To the bast of my knowledge								
8	2 MEDICAL EXAMINER: (On the basis of examination end	d/or investigation, in my	opinion, de	ath occured at the ti	me, date end place, er	nd due to the cause(e) and menner ee stated.		
H	296. SIGNATURE AND TITLE OF CERTIFIER	Tuba in	10		29c. LICENSE NUME	DER 7	29d. DATE SIGNED	(Month/ Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH	UTSM 27 (Ton 200)		DO 22	-51	3/7	-145		
	Richard A	Faran M	12825	011	t 11	21 EL1	/ mi	20744		
	31. DATE FILED (Month, Dey, Year)	32. REGISTRAR'S SIGNATUR		010	Fort K	I FTW	256 111	28744		
Y	MAR 1 3 1995 Juli	Davideor Radall								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT If them 28 is marked or them 23 shows any injury or other traumatic event the medical assembles as account.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certific.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending phe be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene	IMPORTANT If item 28 is marked or item 23 shows any injury or other

FOR STATE REGISTRAR		STATE OF I	MARYLAN	ND / DEPAI CERTIF					MENTA	L HYGIEN REG. NO.	_		
1. DECEDENT'S NAME (Firs		MADEL]	-		_	BARTLEY			2. DATE OF DEATH DAY MARCH 11		YEAR 95	3. TIME OF OEATH 12:25 P.	
236 36 1492 9a. FACILITY NAME (# not li		1 □ M 2 🖾 F	70	yrs. last birthday) YRS.	MONTHS	DAYS Y, TOWN C	HOURS	MIN.	0ct	of BIRTH th, Day, Year)	1924	Count	est Va.
MEMORIAL HOS	SPITAL	over and number)				MBER		ON OF O	EATH		1	LEGAI	VY COUNTY
10a. STATE 10b. COUNTY 10c. CI Michigan Macomb				TY, TOWN OR LOCATION Warren							10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
4124 Tuxed						101	ZIP COD				10g. CIT	U.S.	A .
11. MARITAL STATUS t Never Married 2 3 X Widowed 4 Dive		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO			cify Cube	n, Mexica	n, Puerto	N? (Specify Yea Ricen, etc.)	or No—	14. RACE Black Speci Whit	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTI								sive Co.					
17. FATHER'S NAME (First, A Arthur M. L	ewis			11633 (Shere	A COL				Middle, Malden : Bunner		nulas	PINE CO.
196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Flural Route Number, City or Yown, State, Zip Code) Linda Lee Girlish 4124 Tuxedo St. Warren, Michiga n 48092													
DATE 20. Cremetion 3 Removal from State 20. PLACE AND DATE DISPOSITION (Name of complex), cremetory or other place) White Chapel Cemetery 3/18/95 Troy, Michigan 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY							gan						
Haight Funeral P.O.Box 195 Sykesville, N 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory a shock, of heert failure. List Dnly one ceuse Dn each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						atory an	rest,	Approximate intervel Betwee Onset and Dea					
						the underlying ceuse given in P			Part i. 24e. WAS AN AUTOPSY PERFORMED?		24b.	WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 \(\subseteq \text{NO} \)	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) 10. PLACE OF DEATH (Check only one) 11. PLACE OF DEATH (Check only one) 12. PLACE OF DEATH (Check only one) 13. PLACE OF DEATH (Check only one)													
1 Inpatiant 2 EN/Outpatient 3 DOA 4 Nursing Home 5 Rasidenca 6 Other (Specify)						MUTO 5							
3 Suicide 4 Homicide 6 Could not be determined 28a. PLACE OF INJURY — At home, farm, str building, etc. (Specify)				atreet, tect	treet, factory, office 261. LOCATION (Street a City or Town, State)			ATION (Street as or Town, State)	_				
		CIAN: To the beat of R: On the basis of as											and manner as stated,
30. NAME AND ADDRESS OF	9	S					_	M.E					(Month, Day, Year) 12,1995
Ama	DIVO	COP LETED CAUS		111		NN ST	'REE'	r BAI	LTIM	ORE MAI	RYLAN	ND 21	.201
31. DATE FAMORATORITA Days	1995	32 REGISTRA	R'S SIGNATU	ardally	_								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

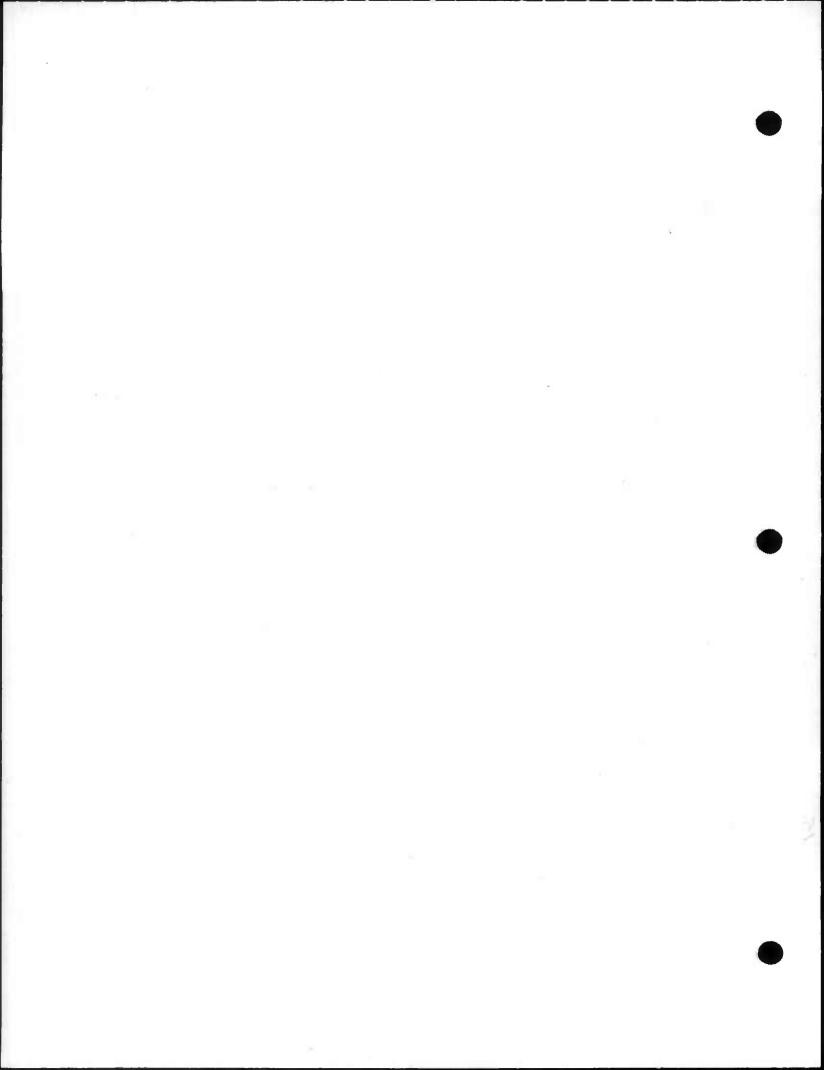
15.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Lest) Dorothy G. Bise			TO DEMI	2. DATE OF DEATH MONTH D	AY YEA	3. TIME OF DEATH				
	- 0	. SEX 6. AGE (In yrs. las	t birthday) IF UN	DER 1 YEAR	March 12, 1995 3°45 A s. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign						
	226-46-0740 1 - M 2 X F 59 YRS. MONTHS DAYS HOURS MIN. June 2, 1935 Cognity)										
OR	96. FACILITY NAME (If not institution, give street end number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH Baltimore 9c. COUNTY OF DEATH Baltimore										
EG	RESIDENCE OF DECEDENT										
DIRECTOR		10d, INSIDE CITY LIMITS? 1 YES 2 X NO									
106. STREET AND NUMBER 9932 Harford Rd. 107. ZIP CODE 2/234 109. CITIZEN OF WHA 2/234 11. MARITAL STATUS 11. MARITAL STATUS 11. Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 3/22NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— 14. RACE— FORCES? 1 Yes 3/22NO 16. Yes specify Cuben, Mexicen, Puerto Ricen, atc.)											
9932 Harford Rd. 2/234 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — An											
BY F	1 Never Married 2 🔀 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 3/20 IF YES, GIVE WAR OR DATES	10	If yes, specify Cuben, Mexic 1 ☐ YES 2 ☑ NO Speci	en, Puerto Ricen, atc.)	В	ACE - American Indien, leck, White, etc. Decity: White				
TED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ripleted) (Gi	CEDENT'S USUAL	ne durina most of workina	16b. KIND OF BUS	SINESS/INDUSTR					
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	achers	d.)	Bal	to. Co	,				
COM	17. FATHER'S NAME (First, Middle, Last) William Henderl		uch chiz	18 MOTHED'S N	AME /First Adjustite Advantage		<u>′ • </u>				
BE	W CLLCAM HENGERL 190. INFORMANT'S NAME (Type/Print)				e Musser						
5	Mr. Ronnie H. B	ise	60 Kin	ess (Street and Number or Rural g Chanles (Cincle Ba	n, State, Zip Code) Lto., M	ld. 2/237				
20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of OATE 20c. LOCATION — City or Town, State Camplety, cramptory or other place)											
- 5	4 Donation 5 Dother (Specify) Gardens Of Faith 3/14 Balto. Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 227 NAME AND ADDRESS, OF FACILITY 227 NAME AND ADDRESS, OF FACILITY										
	22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234										
	23. PART I. Enter the diseases, or comehock, or heart fellure. Lis	t only one ceuse on each line.				ratory arrest,	Approximata Interval Between				
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	M etusta	die)	BLOCKT	PA		Onset and Death				
	a	OUE TO (OR AS A CONSEC					7/2				
NO	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	UENCE OF):								
[S	cause. Enter UNDERLYING CAUSE (Disease or Injury										
CERTIFICATION	that initiated events reaulting in deeth) LAST	DUE TO (OR AS A CONSEC	UENCE OF):								
	PART II. Other aignificent conditions of	ontributing to death but not re	equiting in the	underlying cause given in	Part I. 24s. WAS AN	ALTTOREY A	24b. WERE AUTOPSY FINDINGS				
MEDICAL				and any major and any and any	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
							OF DEATH?				
PHYSICIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		TH YES E OF DEATH (Che		N 🗆						
SIC	EXAMINER?	OSPITAL:	ОТН		6 Other (Specify)						
PH	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. OESCRIBE HOW II	NJURY OCCURED					
2 Accident Investigation M 1 YES 2 NO											
TED	4 Homicide 8 Could not be determined	building, etc. (Specify)			City or Town, State)		arradia riginga,				
COMPLET		N: To the best of my knowledge, des									
) BE	296. SIGNATURE AND TITLE OF CENTIFIES	1/		29c LICENSE NU	814	≥ SIGN	3 (S)				
6	30. NAME AND ADDRESS OF PERSON WHO D	Obseletely cause of DEATH STEN	27) (100-100)	ITE 504	1-12,1		mhan				
	31. DATE FILED (Mogth, Des Merr)	Silonalisate Remodelle	, >0	116 329	100	59/)/	MDZIZZY				
	MAR 1 3 1995										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARTLAND ZIZIS-0020	r death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	examiner must be notified at once.	
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones.	

STATE	0F	MARYLAND A	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	OF	E DEAT	ГН		REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	IEALTH AND	MENTA	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATH			3. TIME OF DEATH
		Ernest Color	na			Ma	_	1995	YEAR	7:27 AM
	4. SOCIAL SECURITY NUMBER	O. AGE IT Y'S. lest Dittionary) IF ONDER 1 YEAR IF UNDER 24							_	LACE (State or Foreign
	213-07-7547		HOURS MIN.	Mar	th, Day, Year)	190		irginia		
~	9a. FACILITY NAME (If not institution, give s		9	b. CITY, TOWN	OF LOCATION OF D	EATH		9c. COUNT		
ğ	Bayview Medio	cal Center		Balti	more			N/	A	
Bayview Medical Center RESIDENCE OF DECEDENT 10a. STATE Maryland Baltimore 10c. CITY, TOWN OR LOCATION Turners Station								10d. INSIDE CITY		
P	Maryland Baltimore Turners Station									LIMITS? 1 Types 2 No
TOP. STREET AND NUMBER 109. CITIZEN OF 121 Center Street 121 Center Street 12. WAS DECEMENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RA 14. RAPPER Married FORCES? 1 VES 2 NO 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— 18. RAPPER NO 19. Specify Cuben, Mexican, Puerio Rican, etc.)								Λ –		
121 Center Street 21222 USA							SA			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U			ENDENT OF HISPA			or No — 1	4. RACE	- American Indian,
BY	1 Never Married 2 Married 3 Never Married 4 Divorced	IF YES, GIVE WAR OR DATE			ecify Cuban, Mexica 2 NO Specific		Rican, etc.)		Specify	White, atc.
	15. DECEDENT'S EDUC	CATION								Black
1	(Specify only highest grade	completed)	6a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done durina mo	ON st of working	16	b. KIND OF BUS	SINESS/INDU	STRY	
7	7th grade	College (1-4 or 5+)	teelwor			[o+h1o	hom	C+ ~,	el Co.
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	[5	OCCI WOI	RCI	18. MOTHER'S NA	_			Stee	el co.
	Absolam Colona				Margai					1
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ODRESS (Street a	nd Number or Rural				(ode)	21784
F	Gloria Burkett				e Drive					ryland
	20e. METHOD OF DISPOSITION 1: Buriet 2 Cremetion 3 Rame		LACE AND DATE OF		me of 2	/ 1 DA)	20c. LO	CATION — CE	ty or Tow	n, Stata
Maryland Nat. Mem. Pk Laurel, Mary								ryland		
	21. SIGNATURE OF FUNERAL SERVICE INC	The state of the s		22. NAME AN	ID ADDRESS OF FA	CILITY	5240	Reis	ter	stown Rd
	Jeny Hu	res		Chatm	an-Hari	ris				e,Md21215
	23. PARTY. Enter the diseases, or o	complications that caused the List only one cause on each	he daath. Do not	enter tha mo	da of dying, suc	h ss car	diac or respi	ratory srres	st,	Approximate
	IMMEDIATE CAUSE (Final	List only ona cause on eac	n line,							Intarval Between Onset and Death
	disease or condition resulting in death) . Acute primanan ederna									
		DUE TO (OR AS A C	ONSEQUENCE OF):	-						
NO	Sequentielly list conditions,	DUE TO (OR AS A C	ONCEONEROR OF							
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DOE TO (OH AS A CO	ONSEUDENCE OF):							
띮	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):							
F	resulting in death) LAST	4.								
	PART ii. Other algnificent conditions	a contribution to death but		to desert						
CAL	11	g contributing to beath but	not recuiting in	tha underlying	r ceuse given in	Part i.	24a. WAS AN PERFOR	MED?		VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
<u>a</u>	Hyporension						1 YES 2	NO		OF DEATH?
Σ	DID TORACCO LISE CONTR	DIDLITE TO CALICE OF	DEATH VEC	D vo B	(1111000000000000000000000000000000000		,		1	YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR		PLACE OF DEATH		UNCERTAIN	<u>и</u> П				
SICI	EXAMINER?	HOSPITAL:		THER:			21			
Ĕ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME C		5 Residence		SCRIBE HOW II	FINSA OCCIN	RED	
	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJUR	Y WO	RK? 'ES 2 NO					
Z Accident investigation								ute Number,		
	4 Homtcide detarmined building, atc. (Specify)									
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowled	ge, death occurred a	it the time, data	end place, and due	to the ca	use(a) and man	ner an stated		
∑	298. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
B		7214			04	130	79	▶ 3	:/8/	95
٩	30. NAME AND ADDRESS OF PERSON WHO		1 (ITEM 27) (Type, Pri	nt)					,	21222
	Theodore Stephens, M.D. 1576 Merritt Blvd. Baltimore, Maryland									
	31. DATE FILED (Morth, Dey, Year) 32. REGISTRAR'S SIGNATURE 33. DATE FILED (Morth, Dey, Year) 34. DATE FILED (Morth, Dey, Year)									

SAME TO SERVE AND ADDRESS OF THE PARTY OF TH

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunlatransit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

VITAL RECORDS, P.O. BOX 68760

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_	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		ENT OF HEALTH AN		L HYGIEN			
ii ii	1. DECEDENT'S NAME (First, Middle, Last)	DECEDENT'S NAME (First, Middle, Last) MICHOLO COTTON				2. DATE OF DEATH MONTH DAY YEAR			
	4. SOCIAL SECURITY NUMBER 002-36-9088 98. FACILITY NAME (If not institution, pive st		IN. NO	OF BIRTH th, Day, Year)	1948 4	BIRTHPLACE (State or Foreign Country) Ob LFEBORD, NH			
FUNERAL DIRECTOR	Se. FACILITY NAME (If not institution, give street and number) Se. COUNTY OF DEATH SE. COUNTY OF DEATH SE. COUN								
	MD · 10b. COUNTY	NA	10c. CITY, TO	WN OR LOCATION				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	100. STREET AND NUMBER	4 ST.		101. ZIP CODE	14		10g. CITIZEN	N OF WHAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAN OR DATES	ARMED NO	13. WAS DECENDENT OF NI If yes, specify Cuban, M 1 YES 2 NO S	SPANIC ORIGI exicen, Puerto pecify:	N? (Specify Yes Rican, etc.)	or No.— 14.	RACE — American Indian, Black, White, atc.	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	AL OCCUPATION done during most of working led.) AL OCCUPATION done during most of working led.) DISABLED							
	17. FATHER'S NAME (First, Middle, Last) CHOR LE	18. MOTNER	S NAME (First,	Middle, Maiden					
TO BE	19a. INFORMANT'S NAME (Type/Print)	S COTTON	196. MAILING ADD	RESS (Street and Number or R		nber, City or Tow	n, State, Zip Co	rde)	
	20a. METNOD OF DISPOSITION	20b. PL/	CEAND DATE OF DIS	SPOSITION (Name of	BAL	70 , N	D · 2	1224 or Town, State	
	4 Donation 6 Other (Specify EUTO MEMBERT LOVELL LAKE CEM. 3-3.95 SANBORD VILLE, NH.								
	22. NAME AND ADDRESS OF FACILITY BALTO, MD. 21224 SKARDA F.H. 2829 HUDSON ST.								
	23. PART i. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition resulting in death)								
NOIL	Sequentially list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	CAUSE (Disease or Injury thet Initieted events resulting in death) LAST								
AL CE	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
PHYSICIAN: MEDIC	Asthma Alcohal alma					1 TYES 2 1 NO COMP		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
SICI	EXAMINER?	HOSPITAL: 1 X inpatient 2 ER/Outpatien	OT	HER: Nursing Home 5 - Resider	nce 6 Othe	er (Specify)			
	27. MANNER OF DEATH 1- Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	286. TIME OF INJURY	28c. INJURY AT WORK?	AT 26d. DESCRIBE HOW INJURY OCCURED			ED	
red BY	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, term, street, building, etc. (Specify)					LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my optnion, death occurred at the time, date and place, end due to the cause(s) and manner as stated.								
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER			29c, LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print)	1741	174000 102/08/95				
	DIDANIEL GOLDSTEIN, JUHNSHOPKIN, BATUIEW MED CET								
TÎ.	MAR 1 3 1995								

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

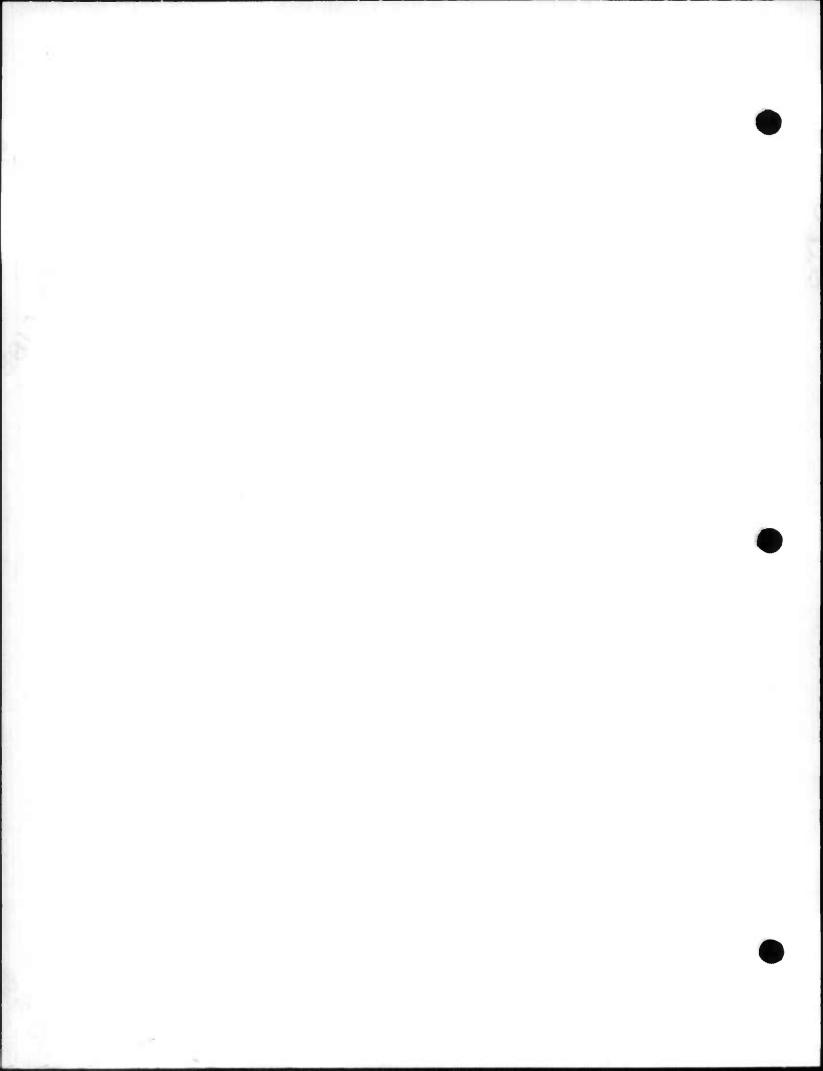
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

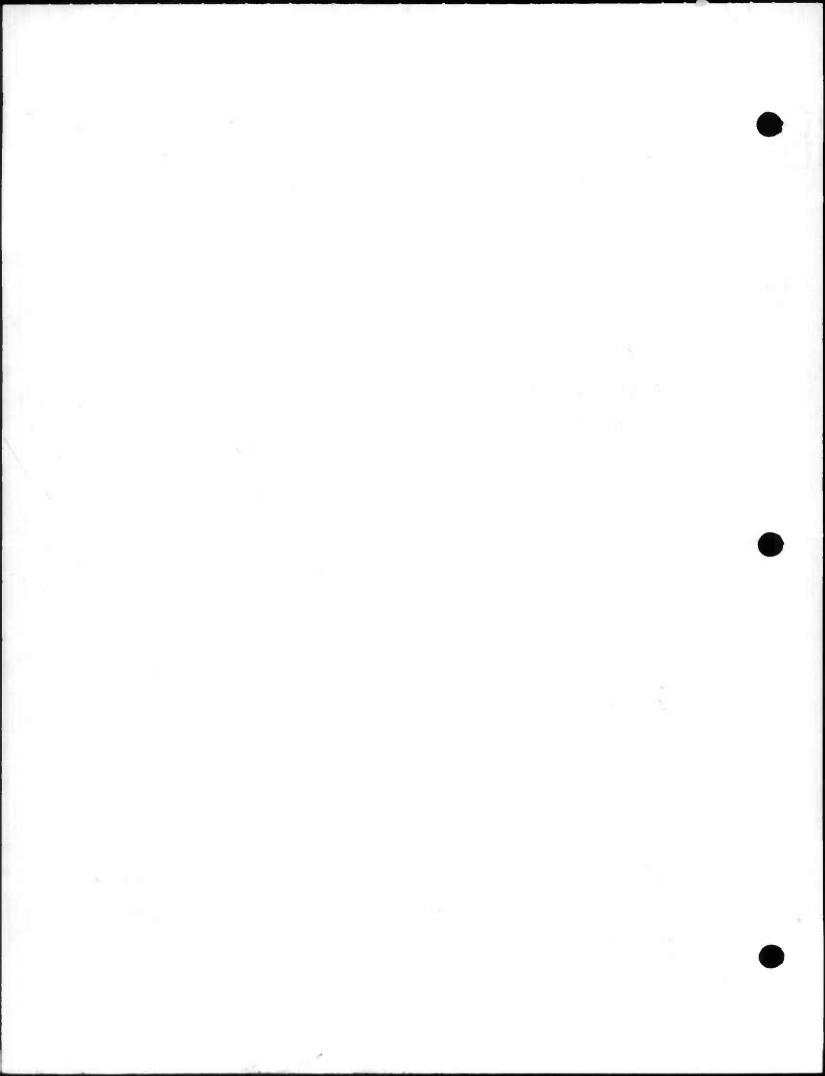
	REGISTRAR		CERTIF	ICATE OF	DEATH	REC	G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE		3. TIME OF DEATN	
	Roland	T	Do.I	aware		MONTH	DAY 100	YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG					07 199		М
	219-40-1842	1 × 2 = F	E (In yrs. lest birthday) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day, SEPT. 28	Year)	8. BIRTHPLACE (State or Forei Country) MARYLAND	sign
	9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOWN	OR LOCATION OF D			TY OF DEATH	
DIRECTOR	821 Belgian Avenu	e		Baltim	ore			n/a	
l m	10a. STATE 10b. COUNT		10c. CIT	Y, TOWN OR LOCA	TION		-	10d. INSIDE CITY	
	MARYLAND n/a			BALTIMORE				1 A YES 2 NO	
FUNERAL	100. STREET AND NUMBER 821 BELGIAN AVE	10	101. ZIP CODE 21218			ED SAT STA			
I S	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EVER	R IN U.S. ARMED	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Ye if yes, specify Cuben, Mexican, Puerto Rican, etc.)				ee or No— 14. RACE — American Indian, Black, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		NO Specif		1000)	Specify: BLACK	-
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	JCATION a completed)	(Give kind of	USUAL OCCUPATI	ON ost of working	16b. KIND	OF BUSINESS/INDU	JSTRY	-
P.E.	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	ise retired.)	redred.) MC DONALD				
O	12 TH 17. FATNER'S NAME (First, Middle, Last)		COOK	-	18. MOTHER'S NA	ME (First, Middle, I	Maiden Sumame)		
BE C		AWARE				E BLANC		ER	
0	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural				
-	DOROTHY DELAWA	\RE	821	BELGIAN	AVENUE,	BALTIM	ORE, MARY	LAND 21218	
	20e. METNOD OF DISPOSITION 1) Surial 2 Cremation 3 Rem 4 Donetion 8 Other (Specify)	noval from State	cometery, crematory or c	OF DISPOSITION (Na other place)		i i	Oc. LOCATION — C		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	GARRISON	FOREST 22. NAME A	VA CEN	1.1.3-13 CIUTY	OWINGS	MILLS, MD	-
	Jusad (Elan		wm . C .	MARCH FH	1 1101	E. NOF	RTH AVENUE	
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if smy, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Onset and Death Onset and Death DUE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other significant condition	ns contributing to death	but not resulting	In the underlyin	a cause alven la	Part I 24a W	AS AN AUTOPSY	24b. WERE AUTOPSY FIND	
DICAL	PART II. Other significant conditions contributing to death but not resulting in the und				g outdo given in	P	ERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAU	
MED						'''	res 2 💢 NO	OF DEATN?	
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YE	ES I NO I	UNCERTAI	N D		1 763 2 100	
N N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
SC	EXAMINER? 1 XYES 2 □ NO	HOSPITAL: 1 Inpetient 2 ER/O	utnetlant 3 DOA	OTHER:	e 5 Residence	- 0 - 1 - 1			\neg
PHYSICIAN:	27. MANNER OF DEATN	280. DATE OF INJUR	Y 28b. TIM	E OF 28c, INJ	URY AT		NOW INJURY OCCI	JRED	\dashv
ВУ Б	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year		M 1 🗆	YES 2 NO				
	3 Suicide 8 Could not be determined	etreet, fectory, office 281. LC		28t. LOCATION (City or Town,	St. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and pleas, and due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the base of examplestion and/or investigation, in my opinion, death occurred at the time, data and pleas, end due to the cause(e) end manner ee stated.								
w	296. SIGNATURE AND TITLE OF GERTIFULE	- 6.671			29c. LICENSE NUM			SIGNED (Month, Day, Year)	
10 B		6 62			O.C.M	.E.	▶ _{Mar}	rch 11 1995	
	David R Far	last or							
(0		0/0 -0-0	TIT Per	m Stree	t, Baltir	nore Mar	yrana 2	LZUI	
	MAR 1 3 1995	32. AEGISTUAR'S 9	ardall,						



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Degr. of Health and Mentral Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAI CERTIF				MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM	W. DA	ARNEY			2. DATE OF DEATH NONTH OF DEAT 10:05			10:05	р	
	4. SOCIAL SECURITY NUMBER 218-26-8865	1X M 2 □ E	E (In yrs. lest birthday) 64 vns.	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	31 MAR		LACE (State or Foreign	gn
ОВ	9a. FACILITY NAME (If not institution, give a MERIDIAN NURS	REEK	96. CITY, TOWN OR LOCATION OF DE REEK ANNAPOLIS			Be. COUNTY OF DEATH ANNE ARUNI					
DIRECTOR	10a. STATE 10b. COUNT MARYLAND ANN	10c. CITY, TOWN OR LOCATION GLEN BURNIE							IOd. INSIDE CITY		
	100. STREET AND NUMBER 8051 WINDING W	101. ZIP CODE				10g. CITIZEN OF)	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	IN U.S. ARMED B 2 NO DATES	N U.S. ARMED 13. WAS DECENDENT OF HISPANI 2 NO Hyper specify Cultur Mexican				NIC ORIGIN? (Specify Yes or No— 14. RACE — America an, Puarto Rican, aic.) 14. RACE — America Black, White, aic.				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	16a. DECEDENT'S (Give kind of life. Do NOT u	6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY					
- 1	17. FATHER'S NAME (First, Middle, Last)	DARNEY	SERVIC	18. MOTHER'S NAME (First, Middle, Maiden					NE REPAIR Sumame)		
TO BE	19a. INFORMANT'S NAME (Type/Print) LOLA J. DARNE		196. MAILING 8051	WIND	Street and	ELSIE d Number or Rural WOOD	MYERS ROUND Number, City or Tow RDAPT:	rn, State, Zip C	[‰] MD GLEN	. 21061 BURNIE	1
	20a. METHOD OF DISPOSITION IX Burla! 2 Cremation: 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Complete Com										
	22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W.GLEN BURNIE, MD.									L	
NO	23. PART I. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart fellips. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. OVGNAVE Heart Caulure, hypotherism onset and Daeth Jule TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, b. MUNO Scleratic Wilated Cardio myopolicy To Yawa								/00/1		
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): If amy, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART-II. Other eignificant conditione contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2X NO 1 YES 2X NO 1 YES 2 NO 1 YE										
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 Residence 6 Other (Specify)									\exists	
Ē	27. MANNER OF DEATH	DEATH 28a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT (Month. Day, Year) 1. INJURY AT (MONDK?						28d. DESCRIBE HOW INJURY OCCURED			
EU 67	2					S 2 NO	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				\dashv
MPLE	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To like best of my knowledge, dasth occurred at like time, data and place, end due to like cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(a) and manner as stated.										
SIGNAPHINE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER 29d. DATE SIONED (Month), Day, Year) ▶ 03/10/95.					
		PETER F. VERKOUW M.D1833A FOREST DRIVE-ANNAPOLIS, MD. 21401									
	31. MAR 1 10 3 1993 Julio Batter South										



CORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Planes 1, 2, 3 should
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

2. DATE OF DEATH

MONTH

AND THE PROPERTY OF

	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	3. TIME OF DEATH					
	Ella L Everett	MONTH 2 DAY 7 YEAR 930 Q M							
	4. SOCIAL SECURITY NUMBER 876 5. SEX 8. AGE (In yrs. lest birthda)) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign					
	21769624 1 M 2 DF 95 YRS.	MONTHS DAYS HOURS MIN.	March 1/ 1909	Country)					
	9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF D		TY OF DEATH					
E E	145 Willowdale Dr. 33	Frederick		ederick					
18	RESIDENCE OF DECEDENT	Treaerica		eaver toll					
DIRECTOR	10a. STATE 10b. COUNTY 10c. C	ITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
	Maryland trederick	tredenck		1 DVES 2 NO					
AL	10e. STREET AND NUMBER	101. ZIP CODE	10g. CITIZ	EN OF WHAT COUNTRY?					
띮	141/ W. Key Parkulay HP	TD 2170:	2	1.5.4					
FUNERAL	11. MARITAL STATUS 2. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, Black, White, atc. 15. Never Married 2. Married 15. Was DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, Black, White, atc. 15. Never Married 15. Was DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, Black, White, atc. 15. Never Married 15. Was DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 16. RACE — American Indian, Black, White, atc. 15. Never Married 15								
ВУ	1 Never Married 2 Married FORCES? 1 YES /2 NO IF YES, GIVE WAR OR DATES		Specify: Specify:						
		Bla							
COMPLETED	(Specify only highest grade completed) (Give kind of	'S USUAL OCCUPATION of work done during most of working use retired.)	16b. KIND OF BUSINESS/INDUSTRY						
12	Elementary/Secondary (0-12) College (1-4 or 5+)	ose relinga.)	NIF						
M	17. FATHER'S NAME (First, Middle, Last)	In is ter	10/1						
	Stephan Trott	100-6	ME (first, Midglie, Maiden Symame)	11 Traft					
BE		NG ADDRESS (Street and Number or Rural							
입	145	11)]]	Route Number, Gity or Town, State, Zip of						
		EOFDISPOSITION (Name of	ur. Treateria						
	11 Purial 2 Cremation 3 Removal from State	othe dace)	DATE 20c. LOCATION - C	And I Co. 1					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	111 00. 01.0	gury rinne	mace mac					
	Markin Col		H-West						
	Tortia, Coron	4300 W	abash Ave						
	23. PART I. Entar the diseass, or complications that caused the deeth. Do ahock, or heart failure. List only one cause on each line.	not entar the mode of dying, suc	h as cardlec or reaplratory arre	st, Approximate interval Batween					
	IMMEDIATE CALISE (Final	1 11		Onset and Daath					
	disease or condition a. Chronic Renal Failure. Due to (or as a consequence of):								
	DUE TO (OR AS A CONSEQUENCE OF):								
Z	Sequentially list conditions. Ly feathser Real dialage.								
Ĕ	if any, lasding to immediate								
5	CAUSE (Disease or Injury	06.							
Ē	that initiated events resulting in death) LAST	OF):							
CERTIFICATION	d								
	PART II. Other significant conditions contributing to death but not resulting	g in the undarlying causa givan in		24b. WERE AUTOPSY FINDINGS					
EDICAL			PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
E I				OF DEATH?					
-	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
Sic	1 YES 2 NO 1 Inpatient 2 TR/Outpatient 3 DOA	OTHER: 4 Nursing Home 5 Residence	e 6 Other (Specify)						
美	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year)	IME OF 26c. INJURY AT	28d. DESCRIBE HOW INJURY OCCURED						
ВУ Б	1 Natural 5 Pending 2 Accident Investigation	M 1 YES 2 NO							
	3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, ferm building, atc. (Specify)	, street, factory, office	281. LOCATION (Street and Number of	r Rural Route Number,					
a L	4 Homicide datarmined		City or Town, State)						
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occur	rred at the time, date end place, and due	the time, date end placa, and due to the cause(e) and manner as stated,						
M	one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigs								
1 12	29b. SIGNATURE AND TITLE OF CERTIFIER								
BE	abilani	26137. ►	SIGNED (Month, Day, Year)						
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (THE	pe, Print)		-1110.					
	Dr Anusha Belant 198	Thomas Tak	nems Dr I	Acart Mad					
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	Thomas Joh	wear Dr fre	ederck Md.					
	3-7-95 MAR 1 2 1995 GI	16 4 4 25							

BALTIMORE, MARYLAND 21215-0020

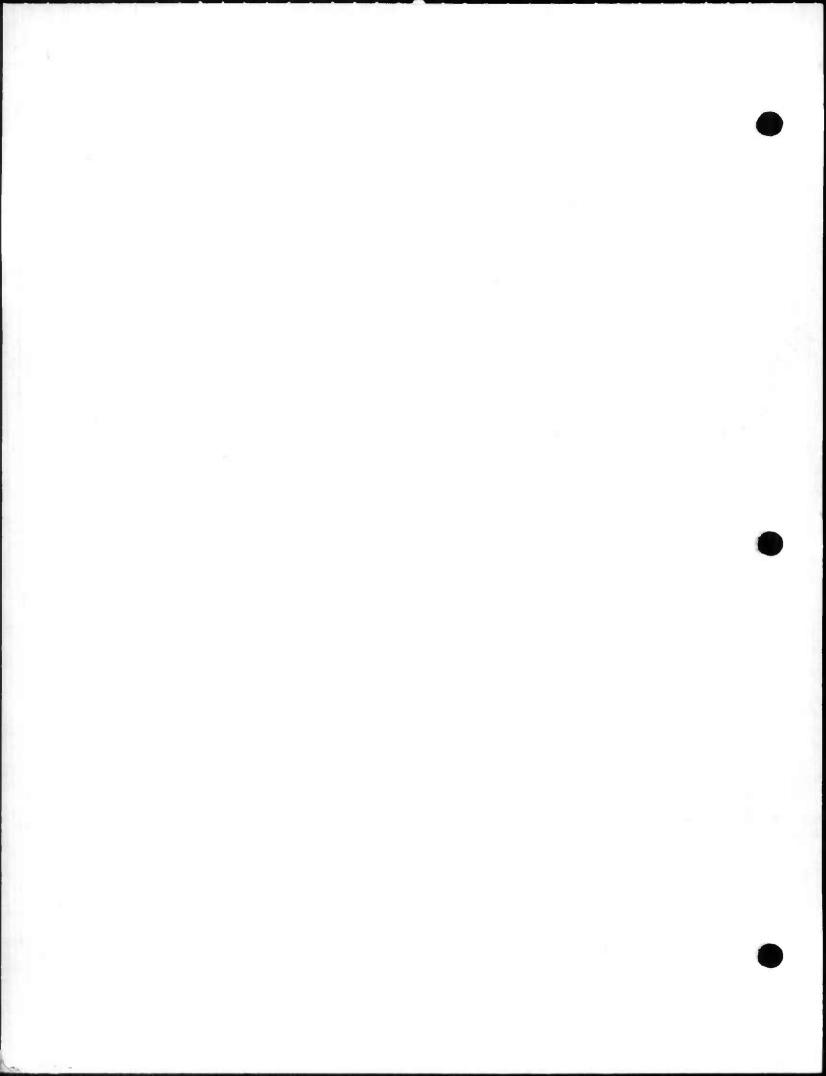
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

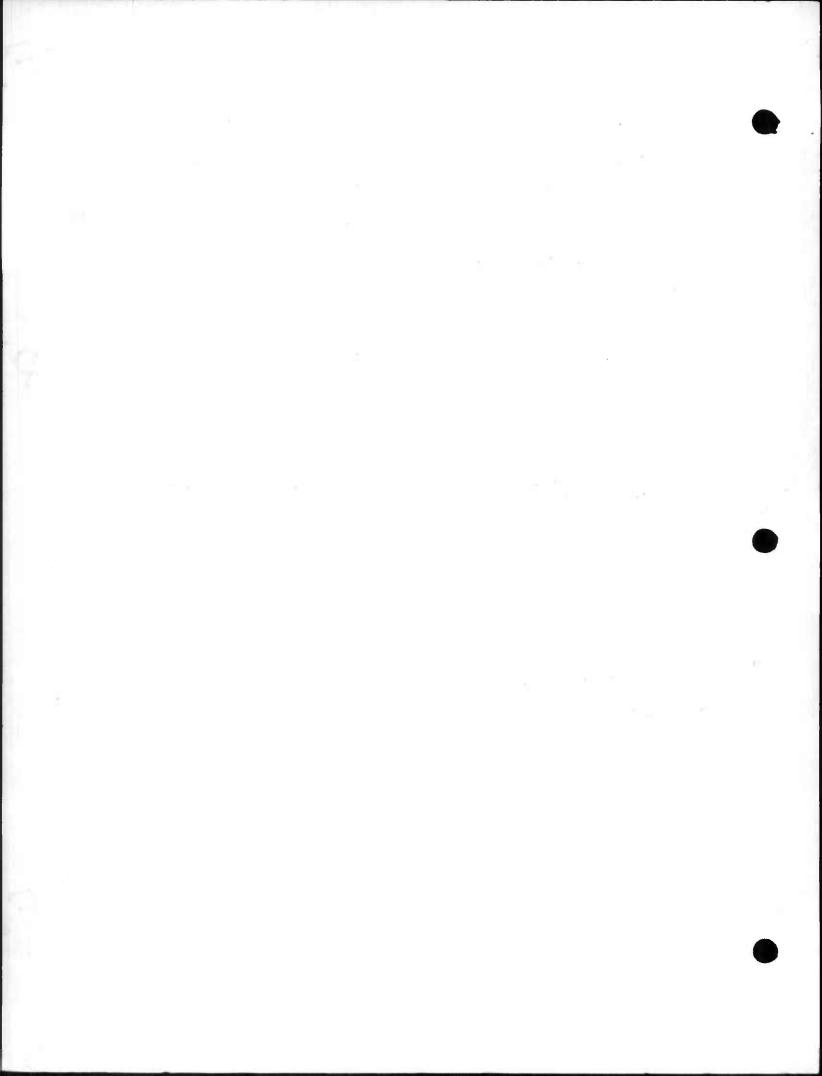
- 0+
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	REGISTRAR		CERTIFIC	CATE OF DEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
	BERNICE EL	IZABETH	CODMAI	NT.		YEAR	12 20 1.	
	4. SOCIAL SECURITY NUMBER		GORMAI (In yrs, lest birthday)	F UNDER 1 YEAR IF UNDER 24 HI		, 1995	1/2,30 /	
	The first over the first over the			ONTHE DAYS HOURS ME	(Month, Day, Year)	Cou		
	218-14-3101	1 M 2 F	07		APR.8,190)/ Vi	ginia	
-	9a. FACILITY NAME (If not institution, give :	street and number)	9	b. CITY, TOWN OR LOCATION O	FDEATH	9c. COUNTY OF	DEATH	
CTOR	Union Memorial Ho	spital		Baltimore		N/A		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT					1 -7.11		
E E			10c. CITY,	TOWN OR LOCATION			10d, INSIDE CITY LIMITS?	
ā	MD	N/A	Bal	timore			1 TY YES 2 NO	
A	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
FUNERA	3810 Greenmount A	venue lst F	loor	21218		U.S.A.		
13	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DECENDENT OF HIS	PANIC ORIGIN? (Specify Yes		CE — American Indian,	
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, specify Cuban, Ma	xican, Puerto Rican, etc.)	Bie	ck, White, etc.	
₽	3 Widowed 4 Divorced	ii ies, dive tan on b	A1 E3	1 TYES 2 NO S	ecity:	Spe	city:	
	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S US	SUAL OCCUPATION	16h KIND OF BU	SINESS/INDUSTRY	Black	
	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of wor life. Do NOT use i	k done during most of working	TOOL KIND OF BO	SINCSS/INDOSTRT		
	5th	College (1-4 or 5+) N/A	Dome		37/3			
once.	17. FATHER'S NAME (First, Middle, Last)	N/A	Dome:		N/A			
5 2					NAME (First, Middle, Maiden	Surneme)		
BB	Step-Father Thoma	s J. Willis		Cass				
2	19a. INFORMANT'S NAME (Type/Print)			ODRESS (Street and Number or Ri				
- 5	Warren Gillespie		3810 (Greenmount Ave	enue 1st FL.	/Baltimo	re, MD 21218	
<u>م</u>	20e. METHOD OF DISPOSITION 1 1 2 Buriel 2 Cremation 3 Rem		D. PLACE AND DATE OF		DATE 20c. LO	CATION — City or	Town, State	
Ē	4 Donation 5 Other (Specify)		netery, cremetory or other	morial Cemete	2 12 Cu	itland.	MD	
i i	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME AND ADDRESS OF	FACILITY		MID	
E		00		March Funera				
<u> </u>	sues a o	1101 E. North Avenue/Baltimore, MD 21202						
9	23. PART I. Entar the diseases, or	complications that ceuse	d tha death. Do not	entar the moda of dying,	uch as cardiac or reap	iratory arrest,	Approximate	
Ē	shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death							
를	disease or condition							
or other traumatic event, the medical examiner must be notified at once. ERTIFICATION TO BE COM	reaulting In death) a							
3	be to for as a consequence of:							
or other traumatic	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):							
AT A	if any, iseding to immediata cause. Entar UNDERLYING	(3)	1 of	ach with	Mathewal	T		
들은	CAUSE (Disease or injury	C. DUE TO COR AS	A CONSEQUENCE OF):	sec will	000000			
e E	that initiated events resulting in death) LAST	20E 10 (011 A3)	CONSCOURNCE OF).					
		d						
any Injury, DICAL C	PART II. Other algnificant condition	na contributing to death t	out not regulting in	tha undarlying cause gives	In Part I. 24s. WAS AN	AUTOPSV 24	b. WERE AUTOPSY FINDINGS	
any Ini	Dune to 1.	The Carlo	eture 1	N/-1	PERFOR	RMED?	AVAILABLE PRIOR TO	
E G	L	, and		or Januar		□ NO	OF DEATH?	
shows		Comeins	ander		~ \		1 - YES 2 - HO	
ღ Z	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	F DEATH YES	□ NO UNCERT	AIN 🗆		. 1	
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	uconit:	26. PLACE OF DEATH					
2 3	1 - YES 2 NO	HOSPITAL:		THER: Nursing Home 5 Residen	ca 6 Other (Specify)			
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME C	F 28c. INJURY AT	28d. DESCRIBE HOW II	NJURY OCCURED		
e 1	Natural 5 Pending	(Month, Day, Year)	INJUR	WORK? M 1 YES 2 TWO				
BY	2 Accident Investigation	28e. PLACE OF INJURY	/ _ At home, form, stre		244 1 00471011 (01-11-11			
28 is	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spec	cify)	et, ractory, office	28f. LOCATION (Street a City or Town, State)	and Number or Rural	Floute Number,	
E	29a, CERTIFIER		*			-		
를로	(Check only CERTIFYING PHYS	ICIAN: To the best of my know	riedge, death occurred a	at the time, date end place, end	due to the cause(a) and mar	nner as stated.		
IMPORTANT: If item 2 O BE COMPLET				in my opinion, death occured at			(a) and manner ea stated,	
EC	29b. SIGNATURE AND TITALE OF GERTIFIE			29c, LICENSE			D (Mpnth, Day, Year)	
2 8	4/1/	is MI)	0 0	1191	D C	18-	
2 ≥	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) / For 0	122	71	15/	1/13 ,	
	30. MAME AND ADDRESS OF PERSON WH	AMD au	76 3623	BUTH BULL	DING, UNCO	N MONO	CAR HOSITAL	
	24 0475 54 55 44 45	1201.	GaNING	20124 1EWY	BALTIMOR	B M10	2/218	
	31. DATE FILED (Month, Day, Year)	A PERMINANTAN	ALLINE	. //				
	MAR 1 3 1995 14	Water and		•				



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		1 - FOR STATE REGISTRAR	TE OF MARYLAND	D / DEPARTA	MENT OF H	IEALTH AND I	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last) ELSIE M.	GASKINS				2. DATE OF DEATH	0AV VI	S 11-15 P M
_	8	370-14-00L7	M 2 X F		UNDER t YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 6 - 9 - 1 9 1 3	8.	BIRTHPLACE (State or Foreign CASHINGTON, D.C
2, 3 should	ECTOR	96. FACILITY NAME (It not institution, give street and Church Hospit			Balti	R LOCATION OF DE MOたと	ATH	9c. COUNTY	
nsit permit. Pages 1,	DIREC	10s. STATE 10b. COUNTY Maryland na	L		own on locate				10d. INSIDE CITY LIMITS? 1 YES 2 NO
	FUNERAL	1036 North Durk	iam Street	t	101	2 1 2 0 5		UNITE	OF WHAT COUNTRY?
by the hospital or attending physician. be detached for use as the burial-transit at once.	BY FUN	1 W Never Married 2 Married FO	S DECEDENT EVER IN U.S. RCES? 1 YES 2, YES, GIVE WAR OR DATES	NO		ecify Cubsn, Mexice	IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	s or No 14.	RACE — American Indian, Black, White, etc. Specify: Black
al or attend for use as	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	ped) 16s.	Give kind of work	done during mo stired.)	st of working	16b. KIND OF BU	ISINESS/INDUS	TRY
he hospita detached once.	OMPI	8 TH -		Hom	emaken		ME (First, Middle, Malder	n/a	
d by th	BE C	JOSEPH GASKINS				JULI			
retained by the 5 should be a notified at	5	196. INFORMANT'S NAME (Type/Print) WALTER VENABLE			N. DUR		EET, BALT		
Page 6 may be retained if director, page 5 should ner must be notified		20s. METHOD OF DISPOSITION Description March Description Descript	m State 20b. PLA cemetery,	CEAND DATE OF E	CEMETE!	RY	3-13 LAN	NSDOWNE	. MD
death.		21. SIGNATURE OF PUBERAL SERVICE LICENSER	onald wad	e, Dir	22. NAME AN	ID ADDRESS OF FA	ore St, B	Anato	omy Board
certificate be executed with mours after ding physician and completely filled in by the tyglene prior to burial, cremation, or removal other traumatic event, the medical is	RTIFICATION	23 PART I. Enter the diseases, or compile ehock, or heert failure. List on iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	ly one ceuse on each	NSEQUENCE OF):		de of dying, auci	haa cardiac or reap	iratory arreat	Approximate Intervel Between Onset and Daath
the death Mental H	AL CERTI	thet initiated events resulting in death) LAST d. PART II. Other significant conditions contri			he underlying	ceuse given in	Part i. 24s. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS
ires that the signed by Health and ws any I	MEDIC	Aspiration pri Sciences	lumouia				PERFO	PAMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
he law requested that been to be Dept. of Im 23 sho	IAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL		AUSE OF		YES NO	- 14.3		
SICIAN: The certificate It the State	PHYSICI	1 VES 2 NO 1 No	PITAL: patient 2 ER/Outpatient	# 3 □ DOA 4		e 5 🗆 Residence	,,		
This with	BY PI	1 Natural 5 Pending 2 Accident Investigation	Bs. DATE OF INJURY (Month, Day, Year)	26b. TIME O	M 1 🗆 Y	RK? /ES 2 NO	26d. DESCRIBE HOW	INJURY OCCUR	ED
TTENDII TOR: A after de	ETED	3 Suicide 6 Could not be 4 Homicide determined	Be. PLACE OF INJURY — A building, etc. (Specify)	t home, farm, atre-	et, factory, office	'	261, LOCATION (Street City or Town, State		Rural Route Number,
TAL OR VAL DIRI 72 hour	OMPLE	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To MEDICAL EXAMINER: On the							euse(s) and manner ee stated.
TO THE HOSPI TO THE FUNES be filed within	BE C	29b. SIGNATURE AND UTLE OF CERTIFIER	UD CUL			29c. LICENSE NUN	18ER 10521	29d. DATE SI	GNED (Month, Day, Year)
	70		50 NORTH	BROA	DWAY,		ORE, MD	2123	1
		MAR 1 3 1995	Maistan Randu	4	**				



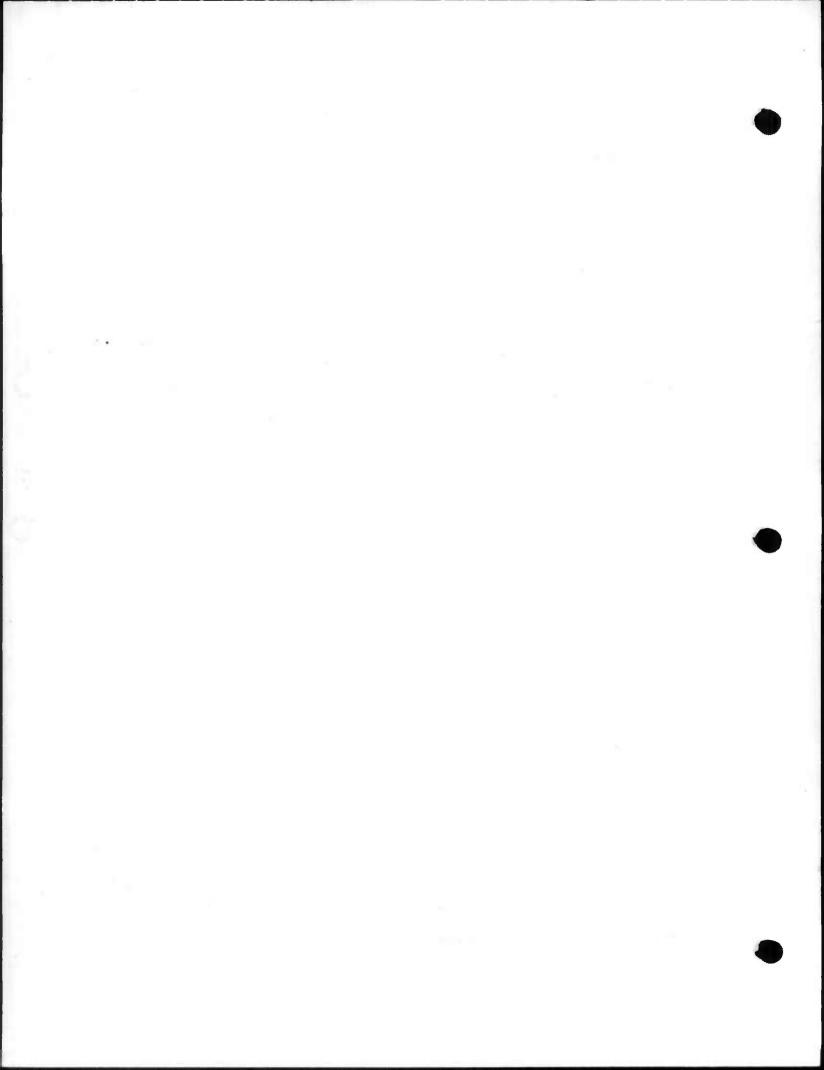
BALTIMORE, MARYLAND 21215-0020	requires that the death certificate be executed within Ahours after death. Page 6 may be retained by the hospital or attending physicis
	her hours after
DIVISION OF VITAL RECORDS, P.O. BOX 68760	w requires that the death certificate be executed within
DIVISION OF VITAL	L OR ATTENDING PHYSICIAN: The law requi

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within of hours after death. Page 6 may be retained by the hospital or attending physician.

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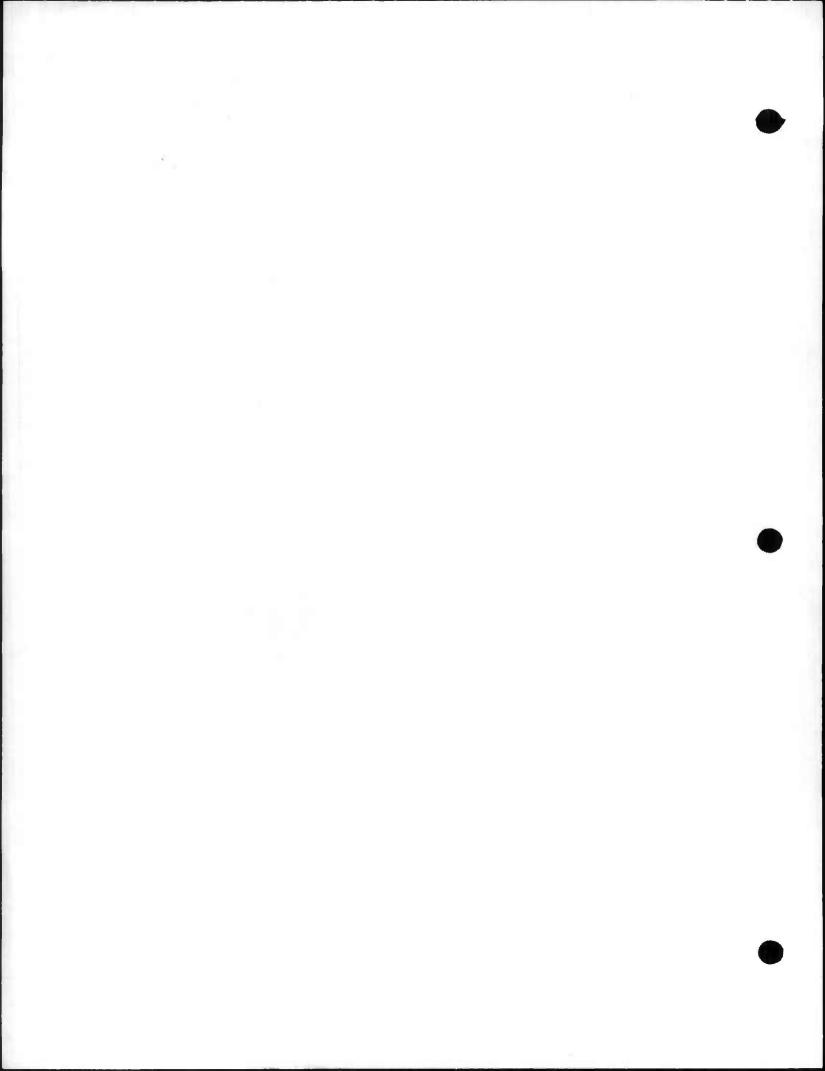
IMPORTANT: If them 28 is marked, or flem 23 shows any Injury, or other traumatic event, the madical examiner must be marked.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HEALTI	H AND MEN	TAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					ATE OF DEATH		3. TIME OF DEATH
١.,	GWENDOLYN DI	ENISE	GREEN					95 11:50 p M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR IF UNDI	DER 24 HRS. 7. D	ATE OF BIRTH	8.	BIRTHPLACE (State or Foreign Country)
	212-58-4602 9a. FACILITY NAME (If not institution, give st	1 M 2 F 41	YRS.	9b. CITY, TOWN OR LOCA		Month, Day, Year)	1953	Maryland
DIRECTOR	THE JOHNS HOPKIN			BALTIMORE			N/	
JË C	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATION				10d. INSIDE CITY
	Maryland Ba	altimore		Woodlawn				LIMITS?
HAI		0 0 1 2 2 1 2		101. ZIP CO				N OF WHAT COUNTRY?
FUNERAL	6521 Woodgreer	12. WAS DECEDENT EVER II	ALLE ADMED		207		USA	
	1 CNever Married 2 Married	FORCES? 1 YES	2 NO	13. WAS DECENDENT If yes, specify Cut	ban, Mexican, Pu	irto Rican, atc.)	or No— 14	. RACE — American Indian, Black, White, atc.
BY	3 Widowed 4 Divorced	ii izo, dive man on bi	AILS	1 TYES 2 TO NO	O Specify:			specify: Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	:ATION completed)	(Give kind of we	SUAL OCCUPATION ork done during most of work	rking	16b. KIND OF BUS	INESS/INDUS	TRY
E	Elementary/Secondary (0-12)	College (1-4 or 5+) Years	Salog 1	Manager			Lynn	Clothing
OMF	17. FATHER'S NAME (First, Middle, Last)	Tears	Dates I			Store		
	Melvin Green				a Dixo	rst, Middle, Maiden S	Surname)	
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO /	ADDRESS (Street and Numb			State Zin Co	del 01005
7	LaShawn Green			Woodgreen				
	20a. METHOD OF DISPOSITION 1x Burial 2 Cremation 3 Remo		. PLACE AND DATE OF	DISPOSITION (Name of		DATE 20c. LOC		or Town, State
	4 Donation 5 Other (Specify)	W	netary, crematory or oth oodlawn	Cemetery		/95 Woo	odlaw	n, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIGH			22. NAME AND ADDR	RESS OF FACILITY	5240 1	Reist	erstown Road
	ogeny offer	ws		Chatman	-Harri			more, Md21215
	23. PART I. Enter the diseases, or cashock, or heart failure. L	omplications that caused List only one cause on e	the deeth. Do no	t enter the mode of d	lying, auch ea	cerdlec or reapir	atory arrest	
	IMMEDIATE CAUSE (Final	- 1						Onset and Death
	disease or condition resulting in death)	Retoviral DUE TO (OR AS A	encepha	lopathy				month
		References in	CONSEQUENCE OF)	d				80100
<u></u>	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF)					o geors
₹	cause. Enter UNDERLYING CAUSE (Disease or injury	h						
틸	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF)					
CERTIFICATION	de la contra del la contra de la contra del la contra del la contra del la contra de la contra del la con	J						
.AL	PART II. Other aignificant conditions	contributing to death b	ut not resulting in	the underlying ceuse	given in Part	. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS
[중						PERFORI		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDIC								1 TES THO
ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES	□ NO □ UN	CERTAIN-E			,
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)				
14S	1 YES 2 NOT	1 Impatient 2 ER/Outp	atient 3 DOA 4	Nursing Home 5 S				
	1 Pending	(Month, Day, Year)	INJU	OF 28c. INJURY AT WORK? M 1 YES 2		DESCRIBE HOW IN	JURY OCCUR	ED
ЭВУ	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY	- At home, farm, atr		261.	LOCATION (Street ar	nd Number or I	Rural Route Number,
COMPLETED	4 Homicide determined	building, etc. (Spec	:ny)			City or Town, State)		
PLE	29a. CERTIFIER 1. CERTIFYING PHYSIC	ZIAN: To the best of my know	ledge, death occurred	at the time, data and plac	es, and due to the	cause(a) and mani	ner as stated.	
OM								ause(s) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER				CENSE NUMBER	I	29d, DATE SI	GNED (Month, Day, Year)
TO B	January &	lucher mi			19693			14/95
I to	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, F	N WOH	St 7	Ratt Mr	2-120	-7
	31 DATE FILED (Month, Day Mar)	, REGISTRAR SIGN		, to awrite	201 1	xua Mi	CIZS	<i>ナ</i>
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		REGISTRAR		CERTIF	ICATE O	F DEATH		REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) New E	Gil	bson			2. DATE O	DAY	YEAR 6 30/A	M
		4. SOCIAL SECURITY NUMBER 216–38–2631		(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAY		7. DATE O	F BIRTH Day, Year)	8. BIRTHPLACE (State or Foreign Country)	
pinous		9a. FACILITY NAME (If not institution, give st	reet and number)	33	9b. CITY, TOW	N OR LOCATION OF D			Maryland NTY OF DEATH	_
1, 2, 3 s	DIRECTOR	Harbor Hospital			Balti	more City			NA	
sade	뿐	10a. STATE 10b. COUNTY	•	10c. CIT	TY, TOWN OR LO	CATION			10d. INSIDE CITY LIMITS?	
permit. Pages	AL DI	Maryland Anne	Arundel		31.en Bu	rnie		100 OIT	1 ☐ YES 2 🌠 NO ZEN OF WHAT COUNTRY?	_
isi	FUNER	335 Gatewater Ct.				21060		US		
215-0020 attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1- YES IF YES, GIVE WAR OR O	2 NO	If yes,	Specify Cuben, Mexico Specify NO Specification	an, Puerto Ric		14. RACE — American Indian, Black, White, etc. Specify: Bl.ack	
r atten	ETED	15. OECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUPA work done during		16b. I	(IND OF BUSINESS/IND	USTRY	
0 m 0	IPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT u	ise retired.)	Supervisor	Λ.	sphalt Ser	vice Co	
MARYLAND 2 retained by the hospital 5 should be detached for notified at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	colloge 4	COUSTI	ICLION .			ddle, Maiden Surname)	VICE CO.	
Y Pe I	BE C	Wilbur Gibson						hnson		
MAR retained 5 should notified	5 B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street			r, City or Town, State, Zip	Code)	
	=	Frank Gibson		30 T	incoln	Ave. Cato	nsvi 1	le. Marvl	and 21228	
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION 1 Description Description		D. PLACE AND DATE	OF DISPOSITION		DATE	20c. LOCATION -		
Page I direc		21. SIGNATURE OF FUNERAL SERVICE LIC	Ga ENISE	rrison E		AND ADDRESS OF FA	OH ITM	Owings	•	_
~ = = =		Kevin	, tarken	/			Νι		ral Homes, Inc alto., MD. 212	
y filled in by titlen, or remother		IMMEDIATE CAUSE (Fine)	omplications that cause clist only one cause on a metastate. OUE TO (OR AS A	ach ilna.	not enter the i	mode of dying, suc	h as cerdie	ec or respiratory arm		en
P.O. BOX th certificate be ex ending physician a l Hygiene prior to or other traum:	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE O	PF):					
DS, P the death the atter d Mental		PART ii. Other significant conditions	a contributing to death b	out not resulting	in the undarly	ing cause given in	Part i. 2	4a. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDING	is
COR uires that signed by Health an Health an	MEDICAL						_	PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
AL RE le law requi has been so Dept. of H	ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	ES NO	UNCERTAIL	N 🗆			
VITAL AN: The la tificate has e State De	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only or OTHER:	ne)				
SICIAN: The certificate to the State of the State of term	PHYS	1 YES 2 NO	1 Inpetient 2 PER/Outp			ome 5 - Rasidence				
ON OF DING PHYSI After this c death with	BY PI	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	JURY	NJURY AT WORK? YES 2 NO	28d. DESC	RIBE HOW INJURY OCC	CURED	
SIC DR: A OR: A fter d	G	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, :	street, factory, of	fice	28f. LOCAT City or	ION (Street and Number Town, State)	or Rural Route Number,	
E SE	COMPLET		CIAN: To the best of my knowl R: On the bests of examination						ed. e cause(a) and manner as stated.	
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE C	29b. SIGNATURE AND TITLE OF CENTIFIER	run m			29c. LICENSE NUI	-	29d. DATE	SIGNED (Month, Day, Year)	
	F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	41	Hal CP	ter			٦
		31. DATE FILED (MONTY DON, 1847). MAR 1 3 1995	32. AEGISTRAR'S	ATHING!	-		CTU			1



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal.	ne medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

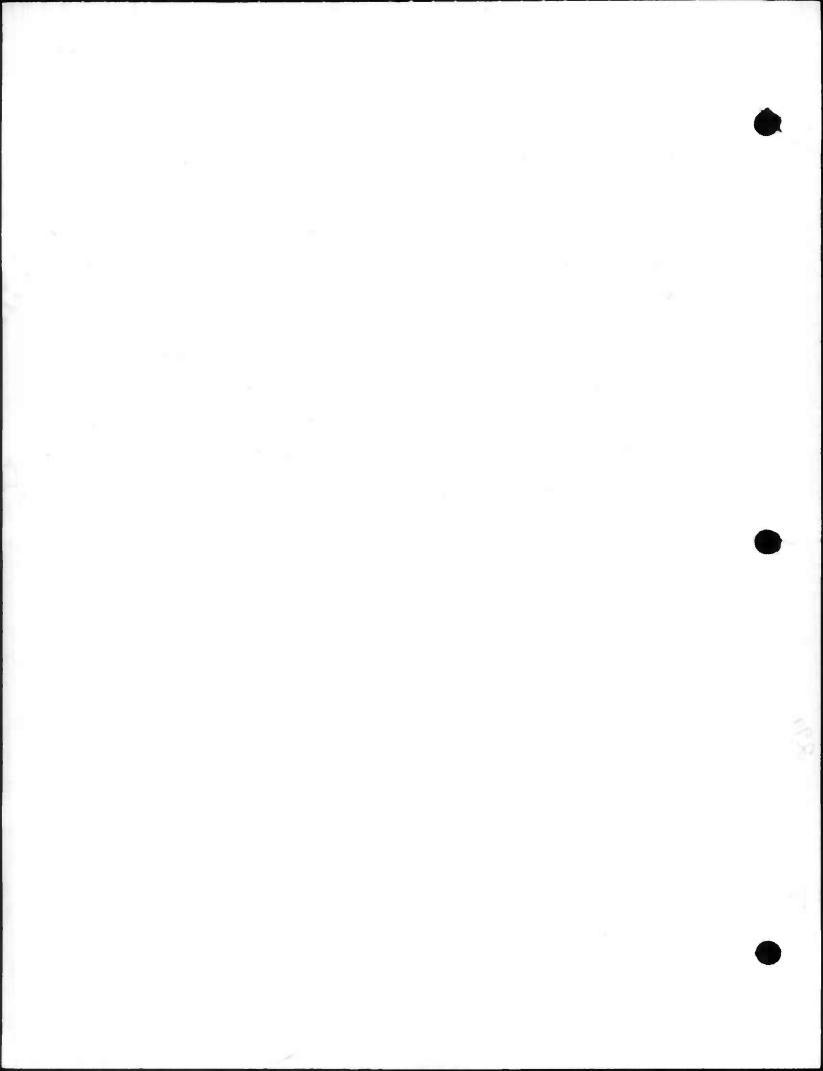
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL	HYGIENE
CERTIFICATE OF DEATH		BEG NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND) / DEPARTMENT () CERTIFICATE (MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Last)	in Gibso			2. DATE OF DEATH	DAY YEAR	College A
	A	5. SEX 6. AGE (In yrs.			7. DATE OF BIRTH (Month, Day, Year)	199 B. Bif	ATHPLACE (State or Foreign untry)
	010 01 1010	et end number)		MN OR LOCATION OF D	TULY 24	9c. COUNTY OF	F DEATH
DIRECTOR	ST AGNES	Hosp.	BAL	TIMORE			-
DIRE	MD. 106. COUNTY	TIMORE	10c. CITY, TOWN OR L	CATION (ALCO II)			10d. INSIDE CITY LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER		and a	101. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN U.S.		DECENDENT OF HISPAI s, specify Cuban, Mexico	NIC ORIGIN? (Specify Y	e or No — 14. R/	ACE — American Indian, ack, White, etc.
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES		YES 2 NO Specif		Sp	PHITE
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	TION 16a. mpleted) College (1-4 or 5+)	DECEDENT'S USUAL OCCUI (Give kind of work done durin life. Do NOT use retired.)	PATION g most of working	16b. KIND OF BI	JSINESS/INDUSTRY	1
MPL	17. FATHER'S NAME (First, Middle, Last)	C	SALESMAN	ز		LVER	
BE CC	ALBERT A,	GIBSON		18. MOTHER'S NA	AME (First, Middle, Maide A FERSI	Sumarne)	
10	19a. INFORMANT'S NAME (Type/Print) MARY ASSNE SHALL	ER	RD#1 BO	eet and Number or Rural	Route Number, City or To	Vn, State, Zip Code)	17327
	20a. METHOD OF DISPOSITION 1 General Burlet 2 Cremetton 3 General Remove 4 General Donatton 5 General Other (Specify)		CE AND DATE OF DISPOSITIO	(Neme of	DATE 20c. L	OCATION — City or	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	22, NAM	E AND ADDRESS OF FA	CILITY BA	TO M	D. 21224
	- Thomas	Atuk	1. Sh	PRDA 1-1	1 2829	40050	
	23. PART I. Enter the diseases, or diseases, or shock, or heart fellure. Lie immediate CAUSE (Final	mplicetions that caused the	death. Do not enter the line.	moda of dying, suc	h ea cerdiec or rea	piratory erreat,	Approximata Interval Between Onset and Daeth
	disease or condition	ACT: 101,01,02	ules				1 wh
	reaulting in death) a.	O DIE TO (OR AC A CON	PECULENCE OD.				
NO	resulting in death)	DUE TO (OR AS A CONS	Shaele				1 wle
CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSTITUTION OF TO (OR AS A CONSTITUTION OF THE CO	Shaele	ua			1 wle
RTIFICATION	sequentially list conditions, if any, leading to immediate	DOE TO (OR AS A CONS	Shaele BEOUENCE OF: 1 Roums	ua			1 wle
빙	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	Should SEQUENCE OF: SEQUENCE OF: Ot resulting in the under	ying cause given in	Part I. 24a. WAS A		/ W/L / W/L 4b. WERE AUTOPSY FINDINGS
SAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	SEQUENCE OF: SEQUENCE OF:	ying cause given in	Part i. 24a. WAS A PERFO	RMED?	1 WLL 1 WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II-Other aignificent conditions of the conditions	DUE TO (OR AS A CONSTITUTION OF TO CONTIDUTING TO death but no	Shaele SEQUENCE OF: SEQUENCE OF: Ot resulting in the under	ying cause given in	1 YES	RMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE
MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II-Other aignificent conditions of the conditions	DUE TO (OR AS A CONS DUE TO (OR AS A CONS DUE TO (OR AS A CONS CONTributing to death but no DOWNER OF DE 26. PL	SEQUENCE OF: SEQUENCE OF: Determined in the under the	ying cause given in	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II-Other aignificent conditions of the conditions	DUE TO (OR AS A CONS DUE TO (OR AS A CONS DUE TO (OR AS A CONS CONTributing to death but no DUE TO CAUSE OF DE 26. PL	SEQUENCE OF: SEQUENCE OF: DEPARTMENT OF LACE OF DEATH (Check only) 28b. TIME OF LINUTRY 18	ying cause given in LULL UNCERTAIL One) Home 5 Residence INJURY AT WORK?	PERFO	RMED? 2 1 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II-Other aignificent conditions of the conditions	DUE TO (OR AS A CONSTITUTION OF INJURY AT LESS PLACE PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS P	SEQUENCE OF: SEQUENCE OF: SEQUENCE OF: Descripting in the under Lac of DEATH (Check only 3 DOA 4 Nursing 28b. TIME OF INJURY M 1	ying cause given in LULL UNCERTAIL One) Home 5 Residence INJURY AT WORK? YES 2 NO	PERFO 1 YES 8 Other (Specify) 28d. DESCRIBE HOW 281. LOCATION (Street	INJURY OCCURED	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II-Other algnificent conditions of the conditions	DUE TO (OR AS A CONSTITUTION OF THE PROPERTY O	SEQUENCE OF): SEQUEN	UNCERTAII UNCERTAII One) Home 5 Residence INJURY AT WORK? YES 2 NO	PERFO 1 YES 8 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State	INJURY OCCURED	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II-Other algnificent conditions of the conditions	DUE TO (OR AS A CONSTITUTION OF INJURY AT LESS PLACE PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS PLACE OF INJURY AT LESS P	SEQUENCE OF): SEQUEN	UNCERTAII UNCERTAII One) Home 5 Residence INJURY AT WORK? YES 2 NO	PERFO 1 YES 8 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State) to the ceuse(s) and ms	INJURY OCCURED and Number or Rura	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
BE COMPLETED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II-Other algnificent conditions of the conditions	DUE TO (OR AS A CONSTITUTION OF THE TO CAUSE OF DE CONTRIBUTION OF THE TO CAUSE OF DE COSPITAL: Inpetient 2	SEQUENCE OF): SEQUEN	UNCERTAIL UNCERTAIL One) Home 5 Residence INJURY AT WORK? VES 2 NO office date end place, end due n, death occured at the	8 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State to the ceuse(s) end ma	INJURY OCCURED and Number or Rura nner as stated, and due to the ceuse	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
E COMPLETED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART IIOther algnificent conditions of the condition	DUE TO (OR AS A CONSTITUTION OF THE PROPERTY O	SEQUENCE OF): SEQUEN	UNCERTAIL UNCERTAIL One) Home 5 Residence INJURY AT WORK? VES 2 NO office date end place, end due n, death occured at the	8 Other (Specify) 28d. DESCRIBE HOW 281. LOCATION (Street City or Town, State) to the ceuse(s) end ms time, date end place, e	INJURY OCCURED and Number or Rura nner as stated, and due to the ceuse	AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO No No No No No No No No No No No No No N
BE COMPLETED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II-Other algnificent conditions of the conditions	DUE TO (OR AS A CONSTITUTION OF THE PROPERTY O	SEQUENCE OF): SEQUEN	UNCERTAIL UNCERTAIL One) Home 5 Residence INJURY AT WORK? VES 2 NO office date end place, end due n, death occured at the	8 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State to the ceuse(s) end ma	INJURY OCCURED and Number or Rura nner as stated, and due to the ceuse	AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO No No No No No No No No No No No No No N



95-074

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/29/95 t.t.

95 07542

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

MARCH 5,1995

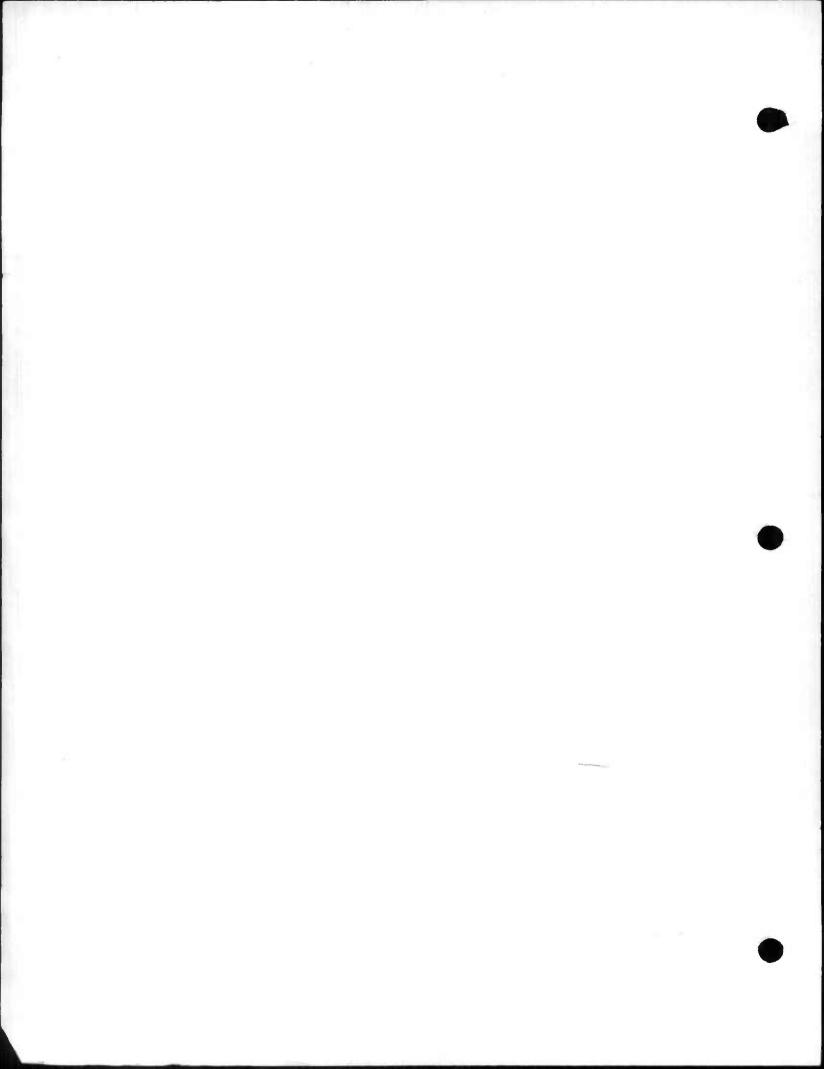
Approximata Intervai Between **Onset and Death**

Р. м

			1 - STATE REGISTRAR	STATE OF MAR	YLAN	D / DEPAR CERTIF	TMENT OF	HEALTH AN	D MEN	TAL HYGIE REG. N			
			1. DECEDENT'S NAME (First, Middle, Last)				-17		MC	ATE OF DEATH	DAY	YEAR	3. TIME OF DEATH
			Darlene 4. SOCIAL SECURITY NUMBER	A.	GE //n u	rs. last birthday)	Giles	IF UNDER 24 HR		RCH	04	95	6:39 P
	pine		216-80-5944 98. FACILITY NAME (If not institution, give s	1 □ M½½□ F	31		MONTHS DAYS	HOURS MIN	JUL	onth, Day, Year)	L963	MAR	YLAND
	, 2, 3 should	TOR	2700 ARBUTUS AV		LC	T		OR LOCATION OF	DEATH			LTIN	ORE
	it. Pages 1	DIRECTOR	10a. STATE 10b. COUNTY	/a	10c. CITY, TOWN OR LOCATION LANSDOWNE							10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	nsit perm	FUNERAL	100. STREET AND NUMBER 2744 LAKEBROOK				21227			10g. CIT		WHAT COUNTRY? STATES	
5-0020	or attending physician. r use as the burial-transit permit, Pages 1, 2,	BY	11. MARITAL STATUS 1 Wever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEND			CENDENT OF HIS	PANIC ORI tican, Puer scify:	GIN? (Specify to Rican, etc.)		14. RACE	— American Indian, c, White, etc.	
21215	or attend use as	ETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	18	e. DECEOENT'S (Give kind of w life. Do NOT us	USUAL OCCUPAT	ION lost of working		16b. KINO OF E	BUSINESS/INC	DUSTRY	
	spital ed fo	BE COMPLE	Elementary/Secondary (0-12) HIGHSCHOOL	College (1-4 or 5+)		unemp					n/a		
MARYLAND	8 6 6		JAMES O. GILES						NAME (FIR IRLE	st, Middle, Maid Y GR	en Sumame)		1 12
MAF	ORE, 6 may be ctor, page	5	190. INFORMANT'S NAME (Type/Print) SHIRLEY GILES			196. MAILING 2936	ADDRESS (Street LAKEBF	and Number or Ru					NDapt.104
ALTIMORE			20e, METHOD OF DISPOSITION 1	oval from State	20b. PL	ACEAND DATE O	FDISPOSITION (N	lame of		ATE 20c. 1	LOCATION —	City or To	
M	. Page al dire		21. SIGNATURE OF FUNERAL SERVICE LIC		141 .	2101		ND ADDRESS OF		I LA	MODOM	VE,	MARYLAND
BAL	after death. Page by the funeral dire- moval.		Jeresa d. (hajoma				C. MARCH					AVENUE
	ed within 24 hours completely filled in t al. cremation, or re- event, the med		23. PART I. Enter the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	CUTTING WOU	n each	line.	AND NECK	ode of dying, a	uch aa c	ardiac or res	spiratory an	est,	Approximata Interval Betwee Onset and De
õ	certificate be execuding physician and Hygiene prior to bur to the traumatic	CERTIFICATION	Sequentielly ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	C		NSEQUENCE OF							
Œ	he law requires that the death that been signed by the atten c Dept. of Health and Mental I m 23 shows any injury, o	EDICAL	PART II. Other algnificent condition	a contributing to deet	h but i	not resulting l	n the underlyin	g cause given	in Part i.		AN AUTOPSY ORMEO? 2 \(\subseteq \text{ NO} \)	24b.	WERE AUTOPSY FINDIN AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
IL RI	law rec as been Dept. of 23 sh	AN: M	DID TOBACCO USE CONTE	RIBUTE TO CAUSE					AIN 🗆				1 YES 2 NO
	- 5 to 0	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	HOSPITAL:			OTHER: 4 Nursing Hor	ne 5 🗆 Resident	e 8 (Vo	ther (Specify)	MOOD		OFF
OF	this with	ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJUI (Month, Day, Yea FOUND: 3-4	RY ar)	286. TIME F UU INJ. 6:34	OF 28c, IN.	JURY AT DRK? YES 2 XNO	28d. 0	BJECT WA			OT
DIVISION	OH ALTENDING DIRECTOR: After hours after death tem 28 is ma	8	3 Suicide 8 Could not be determined	28e. PLACE OF INJU building, etc. (5	specify)	ND: WOODE		a .	C	OCATION (Street ity or Town, State JTUS, BAL	(a) 2700 E	or Aural A	RBUTUS AVE.
0	Ten Disk	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2XXMEDICAL EXAMINED	CIAN: To the best of my kr	nowledg	e, deeth occurre	at the time, date	and place, and d	lus to the	cause(a) and m	nanner aa stat	d.	
	TO THE HOSPITAL TO THE FUNERAL Be filed within 72 h IMPORTANT: If I	H	296. SCHOLINE AND TITLE OF OPPOSITION					29c. LICENSE N	IUMBER		29d. DATI	SIGNED	(Month, Day, Year)
	0 =	٩	30. NAME AND ADDRESS OF PERSON WHO										

Jalla Danilla & Wanter

MAR 1 3 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item29d, Film721.3/16/95, lt

FOR
STATE OF MARYLA
REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

_					<u> </u>	10/11/2	Q.				HEG. NO.			
	1. DECEDENT'S NAME (First	Middle, Last)								2. DATE OF	F DEATH DA		WEAR	3. TIME OF DEATH
	Charles	На	arsha							March	ı 10,	1995	YEAR	2:35 P M
	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH		8. BIRTH	IPLACE (State or Foreign
	142-09-3656	5	1 🕅 M 2 🗆 F	8.3	3 YRS.	MONTHS	DAYS	HOURS	MIN.	Mar 2		11	New	Jersey
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN 0	R LOCATI			_,		NTY OF D	
٣	University	v Hosp	ital			Ba1	tim	ore					N/A	
5	RESIDENCE OF DEC	EDENT												
DIRECTOR	10a. STATE	10b. COUNTY				Y, TOWH OF		ION						10d. INSIDE CITY
	Maryland		N/A		Ba	ltimo	re							NE YES 2 NO
A	10e. STREET AND NUMBER						101	ZIP COD						VHAT COUNTRY?
BY FUNERAL	3448 Elm A	Avenue							212	11			U.S.	Α.
5	11. MARITAL STATUS		12. WAS DECEDEN			13. W	AS DEC	ENDENT C	F HISPAN	IIC ORIGIN?	Specify Yes	or No-	14. RACE	- American Indian,
7	1 Never Married 2		FORCES? 1 IF YES, GIVE W		NO			city Cube 2 NO		n, Puerto Ric	an, etc.)		Speci	k, White, etc.
	3 X Widowed 4 Divo	rced						P	,,,,,,			- 1	орго	White
		EDENT'S EDU		16a.	OECEDENT'S	USUAL OC	CUPATIO	N of of working		16b, K	IND OF BUS	INESS/IND	USTRY	
91	Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NOT us	e retired.)	anny mo	N OF WORK				1 0		
MP	7				Butc	her				Ac	me Fo	od S	tore	
COMPLETED	17. FATHER'S NAME (First, M	iddle, Last)								ME (First, Mid	dle, Malden :	Surname)		
BE	unknown								unkn	.own				
2	19a. INFORMANT'S NAME (1				19b, MAILING	ADDRESS	(Street a	nd Number	or Rural F	loute Number,	City or Town	, State, Zip	Code)	1011
-	Charles R.	Harsh	a		3448	Elm A	ven	ue	Balt	imore	, Mar	ylan	d Z	1211
	20a. METHOD OF DISPOSITI		oval from State	20b. PLA	CE AND DATE	OF DISPOSIT	TION (Na	me of		OATE		CATION —		
	4 ☐ Donation → ☐ Other	(Specify)	7.1 1111-111-1	Gre	en Mou	_					Balt	imor	e, M	aryland
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE / -	1	7			D ADDRE		Jr.	Funor	o 1 H	omo	
	MIL	Slan	- Dec	4	4									yland 21211
	23. PART I. Enter the di	seeses, or o	omplications that	t caused the	death. Do r	ot enter t	he mo	le of dvi	ng. suci	aa cardia	c or respir	ratory arr	est.	Approximate
	snock, or ne	eart failure.	List only one cau	se on each i	ine.			•						Interval Between
	IMMEDIATE CAUSE (Fin disease or condition	ini	CZNCA	of or	v~~>	1117	100	187	- 100					Onset and Death
	resulting in death)		a. Carda DUE TO DUE TO	(OR AS A CON	SEQUENCE OF	10 C	AIK	101						
.,	•	_	Sah	200	\sim	1	10	nw	(V	hzo	2			
<u> </u>	Sequentielly list conditi	ona,	DUE TO	(OR AS A CON	SEQUENCE OF	D:	,	1.6	- 1	170		-		
ķ I	if any, leading to immed ceuse. Enter UNDERLYI	NG								1				
ĔI	CAUSE (Disease or inju that initiated events	ν)	DUE TO	(OR AS A CON	SEQUENCE OF	ŋ:								
CERTIFICATION	resulting in death) LAS	T .	4											
- 19	DART II ON 1 III											120		
EDICAL	PART II. Other significa	nt condition	s contributing to	death but no	ot resulting i	n the und	erlying	cause g	given in	Part i. 2	PERFORI		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ᆲ	-									1	YES 2	NO NO		COMPLETION OF CAUSE OF DEATH?
Σ										_	/			1 TES 2 NO
	DID TOBACCO U		RIBUTE TO CA	USE OF D	EATH YE	S 🗆 N	0 🗆	UNC	ERTAIN	1 🗆				
CIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	28. PI	LACE OF DEAT									
PHYSI	1 YES 2 NO			ER/Outpatient	3 🗆 DOA	OTHER:		5 🗆 Re	sidence	6 🗆 Other (S	Specify)			
E	27. MANNER OF OEATH		28s. DATE OF (Month, D.		28b. TIM	E OF 2	8c. INJU	JRY AT		28d. DESCR	IBE HOW IN	JURY OCC	CURED	
à		Pending nvestigation				М	1 🗆 Y	ES 2 [NO					
	3 Suicide 8	Could not be	28a. PLACE O building,	F INJURY — At atc. (Specify)	home, farm, s	treet, factor	y, office			281, LOCATI	ON (Street ar fown, State)	nd Number	or Rural R	loute Number,
- II	4 Homicide	determined									, , , , , ,			
MPLE	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the beat of	my knowledge,	death occurre	d at the tim	ie, data	and place,	and due	10 the cause	(a) and men	nor as atat	ed,	
WOO N														and manner as stated.
ii li	296. SIGNATURE AND THE		7						NSE NUM					(Month, Day, Year) 1995
ן מ	1	THE						DI	12/	155		▶ AZR	M2C	H10.1004
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (TEM 27) (Type.	Print)		1	JU			a	1-8-10	II O TOTAL
		MD	Shock:	Trum	2 (00	01	22	50.	Cro	000	87 P	th	mo	re Ma
	31. DATE FILED (Month, Day,	-	A2. REGISTRA	Sich ADING	1	-		5-	- 12	٠. ٧	317 6	V V) I		
	MAR 1 3 199	5 July	W Wington	nerces	1	_	1							
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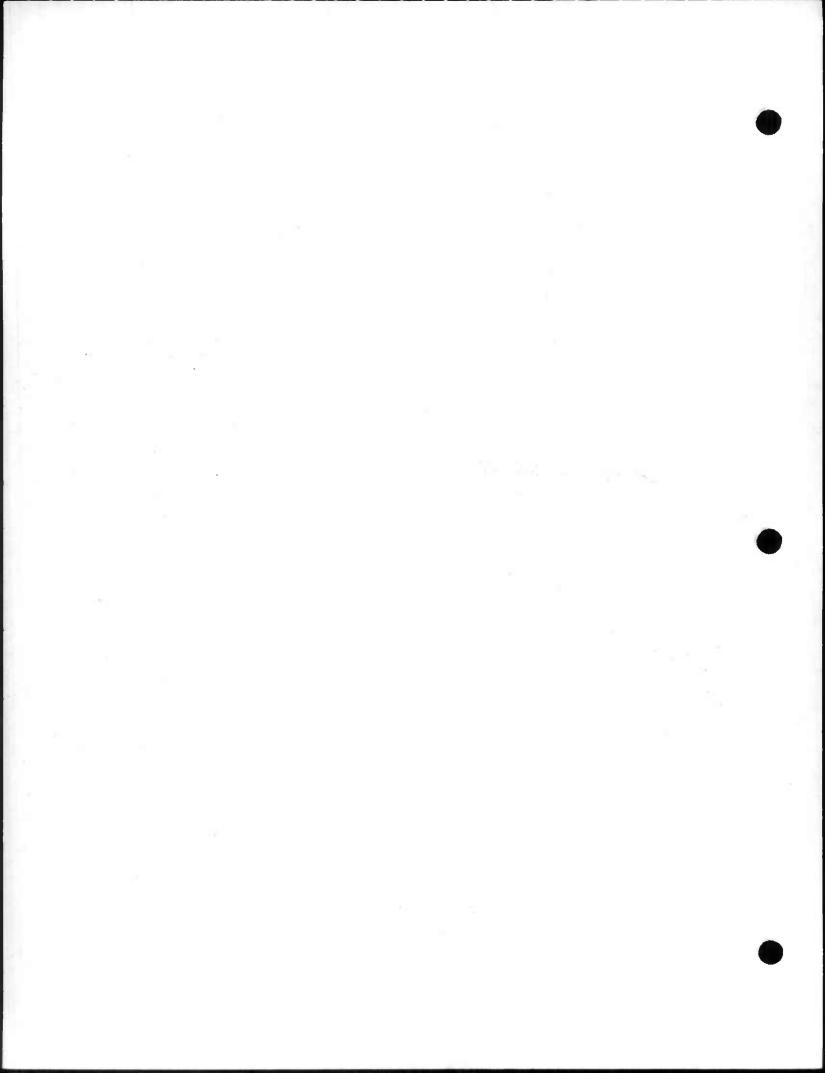
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-Es hours after death. Page 6 mis	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MAR 1 3 1995

	FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAI	ND / DEPAR	TMENT O	F HEALTH OF DEAT	AND MEN	ITAL HYGIEN	E	07044
		ME (First, Middle, Last)	lyn Gera	ldine		ICATE	JF DEAI	2.0	REG. NO.	95 °	a. TIME OF DEATH 12:15 P M
	4. SOCIAL SECURIT	559	5. SEX	□ M 2 🗶 F 87 YR			#FUNDER 1 YEAR #FUNDER 24 HRS. 7 MONTHS DAYS HOURS MIN. N			6.	BIRTHPLACE (State or Foreign Country) Maryland
CTOR	Maridan	- Long G				96. CITY, TO Balti	MOTE	ON OF DEATH		9c. COUNTY N/A	OF DEATH
DIREC	10a. STATE	10b. COUNT	imore		10c. CIT	Y, TOWN OR L	Tows	on			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND N	vern Avenu	16				10f. ZIP CODE	204		10g. CITIZEN	OF WHAT COUNTRY?
B	III I I I I I I I I I I I I I I I I I	S Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X NO	If yo	DECENDENT O	F HISPANIC O	RIGIN? (Specify Yes arto Rican, etc.)		
PLETED	(Sp Elementary/Seco	15. DECEDENT'S EDU becify only highest grade endary (0-12)	College (1-4 or 5 2 yrs	+)	6a. DECEDENT'S (Give kind of ville). Do NOT us Nurse	work done durin	PATION g most of working	g	16b. KIND OF BUS		TRY
once.	17. FATHER'S NAME			•	nurse		18. MOTH	IER'S NAME (F	Private First, Middle, Malden		Nursing
BE at	Geo	orge Piets	sch		195 MAILING	ADDRESS (Se		Mary	"unkno		Erbin
TO TO	II.	A. Dearchs	3						n, MD 212		de)
must b	20a. METHOD OF DI 1 Burial 2 X C 4 Donation 6 (remetion 3 - Ram	oval from State	20b. Pi	LACE AND DATE OF A COLOR OF A COL	of dispositio	N (Name of	03/13	DATE 20c. LOC /95 Balt	imore	or Town, State
examiner	21. SIGNATURE OF	FUNERAL SERVICE LICE		w		Crem	ation S	ociety	y of Mary Baltim	yland,	Inc.
int, the medical examiner must	23. PART I. Enter shock IMMEDIATE CAU disease or condi- resulting in dast	r tha diseasea, pr k, or haart failure. SE (Final ition	a. CEVE	iaa on eac	h lina.	not enter the	mode of dyla	ng, such ea	cardiac or respin	atory arrest	Approximate Interval Between Onset and Death
or other traumatic event,	Compositelly that			IOB AS A O	ONEFOLIENOE OF	1201/17	XD 807				
or other traumatic	If any, leeding to cause. Enter UNI CAUSE (Disease that initiated eve reaulting in deat	conditions, immediate DERLYING or injury	b. DUE TO	OF AS A CO	ONSEQUENCE OF	13/4 CC	sosis Ation				
F 5	If any, leeding to cause. Enter UNI CAUSE (Disease that initiated eve resulting in deat	conditions, immediate DERLYING or injury	b. DUE TO	OR AS A CO	ONSEQUENCE OF	By Cl	10172				24b. WERE AUTOPSY FINDINGS
shows any injury. MEDICAL CE	If any, leeding to cause. Enter UNI CAUSE (Disease that initiated evereaulting in deat	conditions, o immediate DERLYING or injury onts h) LAST	b. DUE TO c. DUE TO d	OR AS A CO	ONSEQUENCE OF ON	In the under	lying ceuse g		PERFOR	MED?	24b, WERE AUTOPSY FINDINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
shows any injury. MEDICAL CE	If any, leeding to cause. Enter UNI CAUSE (Disease that initiated eve resulting in deat	conditions, o immediate DERLYING or injury onts h) LAST	DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO	(OR AS A CO	ONSEQUENCE OF DEATH YE	F): In the under S NO N (Check only OTH)	iying ceuae g	elven in Part	PERFORI	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
or item 23 shows any Injury, YSICIAN: MEDICAL CE	If any, leeding to cause. Enter UNICAUSE (Disease that initiated evereauiting in deat PART II. Other al DID TOBAC 25. WAS CASE REFE EXAMINER? 1 YES 2 (3) 27. MANNER OF DEA	conditions, o immediate DERLYING or injury ents h) LAST	DUE TO C. DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO	(OR AS A CI (OR AS	ONSEQUENCE OF DEATH YE. PLACE OF DEAT	F): In the under S	lying ceuse g	ERTAIN Stdenca 6 28d.	PERFORI	NO NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
28 is marked, or item 23 shows any injury. TED BY PHYSICIAN: MEDICAL CE	If any, leeding to cause. Enter UNI CAUSE (Disease that initiated evereauiting in deat PART II. Other al DID TOBAC 25. WAS CASE REFE EXAMINER? 1 YES 2 VI 27. MANNER OF DEA	conditions, o immediate DERLYING or injury ints h) LAST Ignificent condition CO USE CONTINUES TO MEDICAL AO ATH 5 Pending	DUE TO C. DUE TO d. DUE TO A CONTributing to RIBUTE TO CA HOSPITAL: 1 Inputant 2 26a. DATE OF (Month, D) 28a. PLACE O	(OR AS A CI (OR AS	ONSEQUENCE OF DEATH YE. PLACE OF DEATH INJ	The under S NO H (Check only OTHER: 4 Submining E OF 28c URY M 1	UNC	ERTAIN Seldence 6 128d.	PERFORI 1 YES 2 Other (Specify)	NO NO	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
28 is marked, or item 23 shows any injury. TED BY PHYSICIAN: MEDICAL CE	If any, leeding to cause. Enter UNICAUSE Disease that initiated evereauiting in deat PART II. Other al DID TOBAC 25. WAS CASE REFE EXAMINER? 1 YES 2 Y 27. MANNER OF DEJ Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 [conditions, o immediate DERLYING pr injury ints h) LAST ignificent condition CO USE CONT RRED TO MEDICAL AO ATH 5 Pending Investigation 6 Could not be dytermined CERTIFYING PHYSI MEDICAL EXAMINE	DUE TO C. DUE TO DUE	(OR AS A CI (OR AS	ONSEQUENCE OF STATE O	in the under SS NO H (Check only OTHER: 4 Sururaing E OF 28c URY M 1 street, factory,	UNCIONE) Home 5 Rate INJURY AT WORK? YES 2 Office	ERTAIN Seldence 6 28d.	PERFORI 1 YES 2 Other (Specify) DESCRIBE HOW IN LOCATION (Street as City or Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
8 is marked, or item 23 shows any injury. ED BY PHYSICIAN: MEDICAL CE	If any, leeding to cause. Enter UIC CAUSE Disease that initiated ever resulting in deat PART II. Other al DID TOBAC 25. WAS CASE REFE EXAMINER? 1 VES 2 3 27. MANNER OF DEA 1 Actidant 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 [29b. SIGNATURE AN	conditions, o immediate DERLYING pr injury inits h) LAST Ignificent condition CO USE CONTINUES TO MEDICAL MO ATH 5 Pending Investigation 6 Could not be detarmined CERTIFYING PHYSI MEDICAL EXAMINE D TITLE OF CERTIFIER WWW.	DUE TO C. DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpatient 2 28e. PLACE Of building, ICIAN: To the best of an incidence of a second of	(OR AS A CI (OR AS	ONSEQUENCE OF STATE OF THE PLACE OF DEATH YE PLACE OF DEATH INJURY At home, ferm, a lege, death occurrend/or investigation.	In the under In	iying ceuae g UNCl pne) Home 5 Rai INJURY AT WORK? YES 2 Doffica dete and place, in, death occurs	ERTAIN Seldence 6 28d.	PERFORI 1 YES 2 Other (Specify) DESCRIBE HOW IN LOCATION (Street as City or Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO FOR THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PRIOR TO PARTY OF THE PA
PORTANT: If Item 28 is marked, or Item 23 shows any Injury, BE COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leeding to cause. Enter UNICAUSE Disease that initiated evereauiting in deat PART II. Other al DID TOBAC 25. WAS CASE REFE EXAMINER? 1 YES 2 N. 27. MANNER OF DEAT SUICIDE 4 Homicide 29a. CERTIFIER (Check only one) 2 [29b. SIGNATURE AN 30. NAME AND ADDRIVER.	conditions, immediate DERLYING or injury ints h) LAST ignificent condition CO USE CONTINUES TO MEDICAL AD ATH 5 Pending Investigation 6 Could not be determined CERTIFYING PHYSI MEDICAL EXAMINE D TITLE OF CERTIFIE	DUE TO C. DUE TO DU	(OR AS A CI (OR AS	ONSEQUENCE OF STATE OF THE PLACE OF DEATH YE PLACE OF DEATH INJ. At home, ferm, a loge, death occurre, and/or investigation. The place of the place	in the under S NO NO (Check only OTHER: 4 SHurning 4 SOF URY M 1 street, factory, n, in my opinic	iying ceuae g UNCl Done) Home 5 Raid WORK? YES 2 Offica date and placa, on, death occure	ERTAIN Seldence 6 28d. NO 28t. and due to the dat the time, NSE NUMBER	PERFORM 1 YES 2 Other (Specify) DESCRIBE HOW IN LOCATION (Street as City or Town, State) e cause(a) and manual date and place, and	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rural Route Number, Buse(a) and manner as stated, GNED (Month, Day, Year)



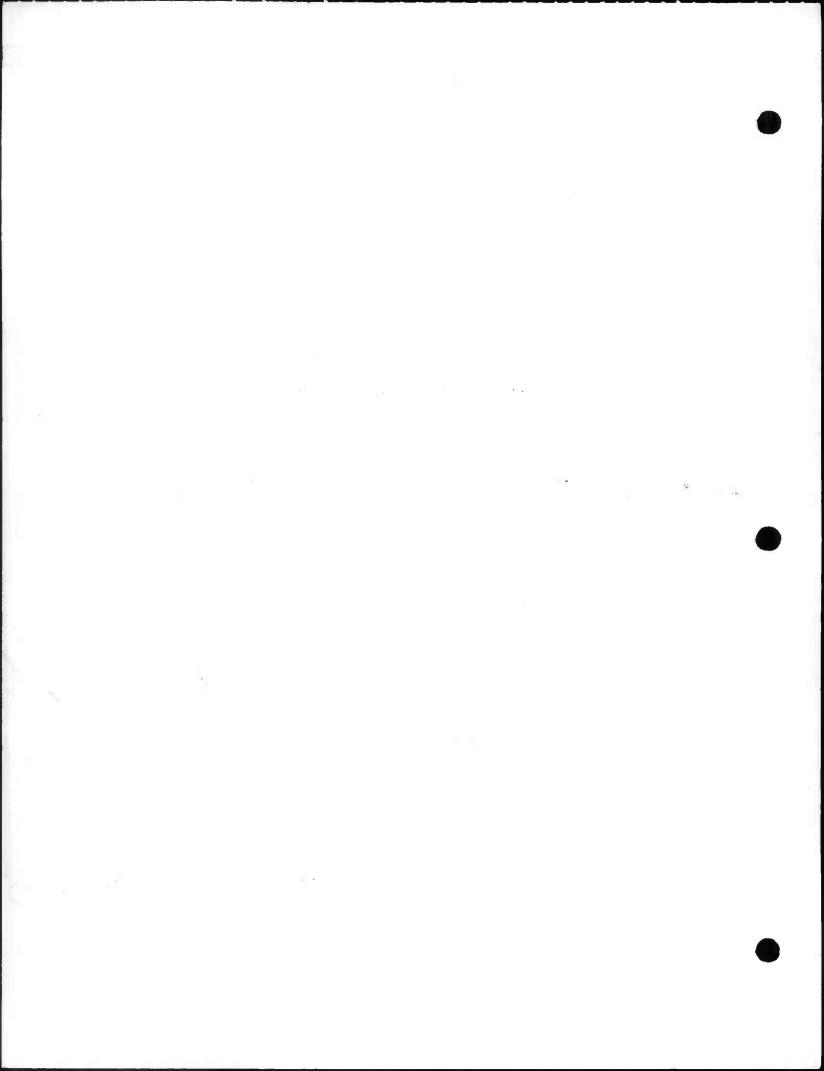
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

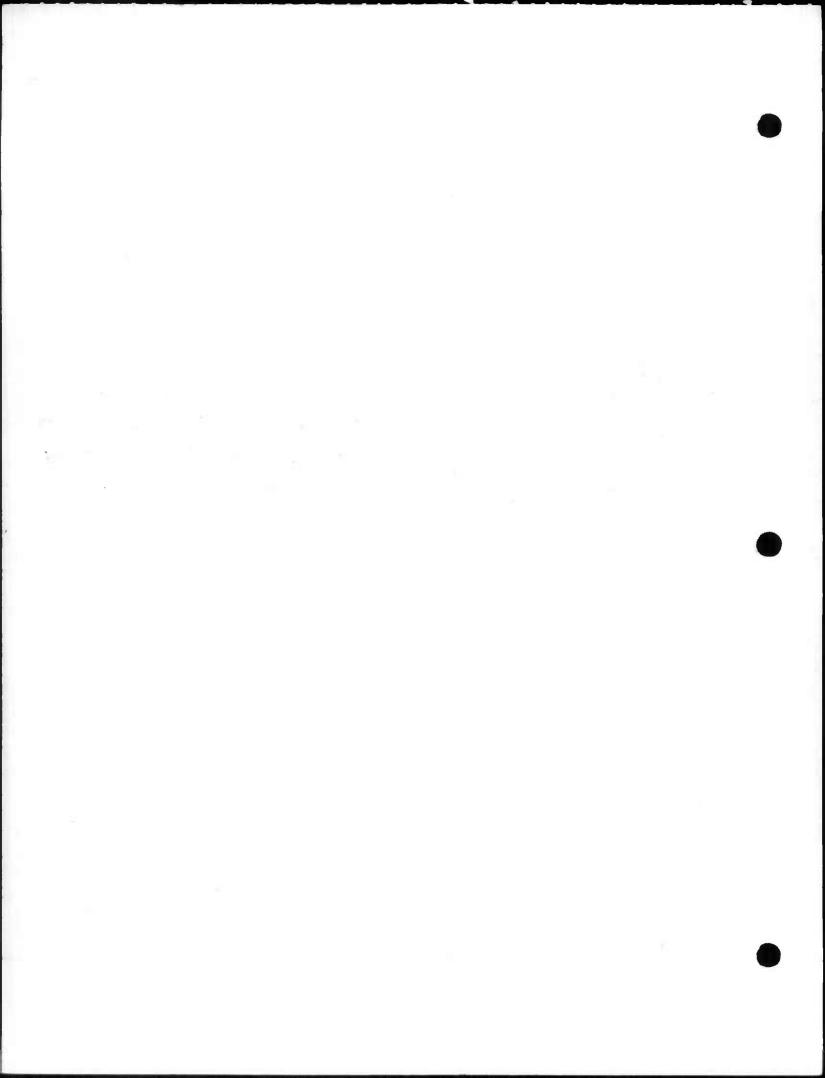
STATE	0F	MARYLAND	/ DEPARTM	MENT OF	HEALTH	AND	MENTAL	HYGIEN	E
		C	ERTIFIC	ATE O	F DEAT	TH		REG. NO.	

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGI					
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	1		3. TIME OF DEATH		
	Kara Kent					MARCH	DAY 19	YEAR	18.50	PM	
	4. SOCIAL SECURITY NUMBER 5.	0. BIRTHP	LACE (State or Forei	gn							
	140-50-6398	□ M 2XX 34	YRS.	ONTHS DAYS	HOURS MIN.	July 18		Country)		7.7	
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
8	Union Memorial Hospital Baltimore City										
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	- /						-/			
E	D.C.	NIA	10c. CITY,	TOWN OR LOCAT		shington			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
	10a. STREET AND NUMBER	11/1				SILLING COL)	
RA		: 11 Tama 1		101.	ZIP COOE	\ o ==			HAT COUNTRY?		
FUNERAL	3209 Cherry H:				200			S.A.			
	1. Never Married 2 Married	P. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yea, spe	cify Cuban, Mexica	NIC ORIGIN? (Specify on, Puarto Rican, etc.)	Yea or No-	Black,	 American Indian, White, atc. 		
B	3 Widowed 4 Divorced	IF YES, OIVE WAR OR DA	ITES XX	1 TYES	NO Specif	У.	1	Specify	White		
	15. DECEDENT'S EDUCATI	ION	16a. DECEDENT'S U	SUAL OCCUPATIO	N	16b, KIND OF	BUSINESS/INDU			-	
	(Specify only highest grade com Elementary/Secondary (0-12)	opieted) College (1-4 or 5 +)	(Give kind of wo	rk done during mos retired.)	t of working						
립	12+	4	Pi	ublish:	ina	For	eign '	Trad	de		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meid					
BE C	Fı	rederick D	E. Kent		Adrie	enne Z.	Kent				
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	DDRESS (Street at	nd Number or Rural	enne Z. Route Number, City or Cive Apt	Town, State, Zip (Code)			
2	Frederick E. H	Kent	22234	Edgewa	ater Dr	ive Apt	. 105	Pla	ort Cha	rl	
	20a. METHOD OF DISPOSITION	20h	PLACE AND DATE OF	DISPOSITION (No	ne of	OATE 20c.	LOCATION — C	ity or Tow	n, State	\neg	
	1 Buriel 2 Fremation 3 Removal 4 Donation 5 Other (Specify)	from State come	etery, crematory or oth etro Cre		7	3/7 Ca	tonev	1116	MD	- 1	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE			D ADDRESS OF FA	ICILITY	COIID V	1110	FID	\neg	
	M. 6.0/	and.				ss Funer					
	22 PART I Fotos the diseases	yserw	U	3631	Falls	Rd. Ba	lto.	MD	21211		
	23. PART I. Enter the diseases, or com shock, or heart fellure. List	only one ceuse on ea	itha death. Do no ach iina.	t entar tha mod	la of dying, suc	h as cardiac or re	spiratory arre	at,	Approximate Interval Bets		
	iMMEDIATE CAUSE (Final disease or condition	0 0000							Onset and D	eeth	
- 1	resulting in death)	C ARDID DUE TO (OR AS A	- RESP	IRATOI	ey .	ARRES"	T		1 Hou	K	
		DUE TO (OR AS A	CONSEQUENCE OF		A						
8	Sequentially list conditions, b	MULTI- (OUE TO (OR AS A METAS TA	CONSEQUENCE OF		410010				1 mox	nH.	
A	If any, leading to immediate cause. Enter UNDERLYING	METACTA	ACIC O		11000	nai			(a MON	nea	
윤	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF	CAI	NOCE IC	CC LL.	2		Q TION	"	
CERTIFICATION	resulting in death) LAST	CERYICA	L C	ANCER	2				12 mor	UTH	
									<u> </u>		
AL	PART II. Other significent conditions of	ontributing to deeth bu	ut not reaulting in	the undarlying	cause given in		AN AUTOPSY FORMED?		WERE AUTOPSY FIND		
8			·			1 [V YES	2 🗆 NO		COMPLETION OF CAU	SE	
뿔								1	I TES 2 NO		
ž	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	F DEATH YES	□ NO □	UNCERTAIL	NΧ				- 4	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	QSPITAL:	26. PLACE OF DEATH								
1S	1 YES 2 NO 1	Inpetient 2 - ER/Outpe		OTHER: Nursing Home	5 Residence	6 Other (Specify)					
표	27. MANNER OF OEATH	28e. OATE OF INJURY (Month, Djay, Ybar)	28b. TIME INJU		RY AT NA	26d. DESCRIBE HO	W INJURY OCCU	JREO			
ВУ	1 Netural 5 Pending 2 Accident Investigation	N/A	N/4		ES 2 NO	N/	A				
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Speci	At home, ferm, str	eet, factory, office		28f. LOCATION (Stre City or Town, Str	et and Number o	r Rural Ro	ute Number,		
	4 Homicide determined		N/	}		^	J/A			_	
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the beat of my knowle	edga, death occurred	at the time, date	end plece, and dua	to the cause(a) and	manner ea atate	d.		\neg	
8	one) 2 MEDICAL EXAMINER: O								and manner as state	ed.	
	29b. SIGNATUME AND TITLE OF CERTIFIER	77	~		29c. LICENSE NUI				Month, Day, Year)	-	
BE	Andanie	x m	, P]	ATOUZ	2946 E5		A WY L		ar	
임	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type: F	rint)	171 270			HKU[]	4 17	95	
	ANNA DAVID M.D	UNION M	EMORIA	L HOCDI	TA 2	UEU	niv P	KW	4211-		
	31. DATE FILED (Month, Day, Year)			1100/1		xuu vu	y m	1) 0	14216	-	
	MAR 1 3 1995 July	32. REGISTRAR'S SONA	dall								
	INDA T O 1000										



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			REGISTRAR	CE	HITFICATE OF	DEATH	REG. NO		
			1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH
			WILLIAM	KEI	ELING		MAR. 8	1995	1/Pm "
			4. SOCIAL SECURITY NUMBER 5	6. SEX 6. AGE (Inpyrs. last			7. DATE OF BIRTH	6. BIRTH	IPLACE (Inste or Foreign
		1	382-03-8316	M2 F CL	YRS, MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	111 115	Eainia
	should		9e. FACILITY NAME (If not institution, give stree	et end number)	9b, CITY, TOWN	OR LOCATION OF D	EATH	9c, COUNTY OF D	EATH
	85 F8	Œ	Irvington Knoll	·	Balti		,	1//	7-0
	2	CTOR	RESIDENCE OF DECEDENT	Care Center	Daits	rmore		IV H	
	Pages 1,	EC	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCA	ATION			10d. INSIDE CITY
	Se.	DIRE	Maryland		Baltimore	2			1 A YES 2 NO
	permit.		10e. STREET AND NUMBER			of, ZIP CODE		10g) CITIZEN, OF V	
	# B	RA	22 South Athol	Auroniio		21229		122	TAI COUNTAT?
	physician. burial-transit	FUNERAL						1000	le
20	nysici ırial-	교	11. MARITAL STATUS 1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN U.S. ARN FORCES? 1 1 YES 2 NO		ECENDENT OF HISPA specify Cuben, Mexico	NIC ORIGIN? (Specify Yes	or No- 14. RACE Black	E — American Indian, k, White, etc.
5-0020	ing ph the bu	ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		S 2 NO Speci		Speci	"RIACL
r,	or attending physician. r use as the burial-tran			W.W. IF					DIMA
21	use use	1	15, DECEDENT'S EDUCAT (Specify only highest grade cor		CEDENT'S USUAL OCCUPAT to kind of work done during in Do NOT use retired.)	FION nost of working	16b. KIND OF BUS	SINESS/INDUSTRY	
2	for Jo	"	Elementary/Secondary (0-12)	College (1-4 or 5+)			1/1 1	11'	8.30
AND	he hospit detached once.	₹ I	4		ADORER		DAIDY)ulldix	19
A		COMPLETED	17. EATHER'S NAME (First, Middle, Last)	1 .		16. MOTHERS N	AME (First, Middle, Maiden	Surname) / /	X
Ξ.	2 2 E	ш	L) Ames	eeling.		Hale	(1A) E	HOHO	X
AB	5 should notified	В	194/INFORMANT'S NAME (TOWNSON)	11 1 1 199	MAILING ADDRESS (Street	and Number or Furny	Floute Number, City or Res	n Sign. Zip Gode) \	2/
	5 5	유	VIRginia Moul	trie 4	70 LENOX	Ave. L	OT GB	nui	JU 1005/
ш	ay be		ZQL METHOD OF DISPOSITION	20b. PLACE A	ND DATE OF DISPUSED ON A	Winfu T	DATE 200 LO	CATION - Dity or To	on State 1
TIMOR	ector. pag must be		1 Hurtal 2 Cremation 3 Ramova 4 Donation 5 Other (Specify)	f from State	natory or other plann	too	3/14/20	0.015	my
Σ	dire dire	1	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE / CHISK	15 on VITTE	AND ADDRESS OF H	SIT CIA	RRISON	11/4
E.	death. Pag tuneral di L examiner		.41	0 / /	/ Marsh	all W./	Jones, Jr	. Funer	al HM PA
BAL			Juria (4)	Jama hus	4101		on Ave.		
ш.	E 3 6		23. PART I. Enter the diseases, or con	nplications that seed the dea					Approximate
	filled in I			at only one cause on each line.					interval Between Onset and Death
	15 m		iMMEDIATE CAUSE (Final disease or condition	Caldia	Oursel-				
0	completely fille ial, cremation, event, the		resulting in death) a	DUE TO (OR AS A CONSECU					1 5 minutes
68760	8 5 - 6					dia	3		15 minules
68	and com burial, burial,	NO N	Sequentisity list conditions, b.	DUE TO (OR AS A CONSECU		disea	se		speaks.
XO.		E	if sny, leading to immediate cause. Enter UNDERLYING						10,400,00
8	physician ne prior t	길	CAUSE (Disease or injury C	Hyperte	ension				10 years
0		E	that initiated events resulting in death) LAST			0	4 0 -		
۵.	9 =	CERTIFICATION	d	autherose	deronc	heart	- desea.	re	loyears
S,	rne death / the atte d Mental injury,	- 1	PART ii. Other algnificant conditions of	contributing to death but not re	suiting in the underlyle	na cause alven in	Part i. 24s. WAS AN	AUTORCY 24h	. WERE AUTOPSY FINDINGS
RD:	by the	DICAL	Periphera	0 0 0			PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
00	signed by lealth and						1 _ YES 2	DENO	DF DEATH?
RE	of He	×	Cerebroro		ccuident			<i>'</i>	1 TYES 2 NO
	has been so Dept. of H	ä	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF DEAT	H YES NO	☐ UNCERTAL	N 🔯		
Z.	State Do	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		OF DEATH (Check only one	9)			
VITAL		Sic		IOSPITAL: Inpetient 2 ER/Outpetient 3	□ DOA 4 Nursing Ho	me 5 🗆 Residence	6 Other (Specify)		
T !	certification of the	Ŧ	27. MANNER OF DEATH	26e. DATE OF INJURY		JURY AT	26d. DESCRIBE HOW I	NJURY OCCURED	
0	fter this c eath with marked,	7	1 Netural 5 Pending	(Month, Day, Year)		YORK?			
ō	T. After death	ВУ	a Catta	26e. PLACE OF INJURY — At horr	ne, farm, atreet, fectory, offi	Ice	28f. LOCATION (Street of	and Number or Rural I	Poute Number
S	ALLENDING ECTOR: After s after death 1 28 is ma		4 Homicide 6 Could not be	building, etc. (Specify)			City or Town, State)		out rumou,
DIVISION	DIRECTOR: After hours after death	<u> </u>	29e. CERTIFIER DE OFFITIENTO SUPPLIER						
	7 7 N	릴	(Check only	iN: To the best of my knowledge, dear					
ě	TO THE HUSPITAL OF YOUR TO THE FUNERAL DIRE BE filed within 72 hours IMPORTANT; If Item	COMPL	2 MEDICAL EXAMINER: (On the basis of examination and/or in	westigation, in my opinion,	death occured at the	time, date and place, an	d due to the ceuse(a) and menner se stated.
	A B E E	ш	29b. SIGNATURE AND TITLE OF CERTIFIER	`		29c. LICENSE NU		29d. DATE SIGNED	(Month, Dey, Year)
	TO THE De filed	0	SabaSido	lean Phys	rician	D41	1496	▶ 3/	9/95
		2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH (ITEM	27) (Type, Print)		/		// / 3
			DR SABA SIL	DOIRI P	elican 27) (Typo, Print) OBOX 131:	3 SYKA	epville N	10 21	784
			31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	- RUN I OF	// ((11011	- /	. 07
			MAR 1 3 1995 Julia	Studior Radall					
	l		MAU 1 9 1333 3000	MININGSOC NAME OF					
-									DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPAR CERTIF	RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIENE REG. NO.	
. 7	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY Y	3. TIME OF DEATH
	YOLANDA 4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday)	LEGRAND IF UNDER 1 YEAR IF UNDER 24 HRS.	MARCH 8, 1995	7:25P M
	219-86-6051	1 M 2 X F 30 YRS.	MONTHS DAYS HOURS MIN.		BIRTHPLACE (State or Foreign Country)
~	9a. FACILITY NAME (If not institution, give	street and number)	9b. CITY, TOWN OR LOCATION OF DE	11.14.9	OF DEATH
DIRECTOR	THE JOHNS HO	PKINS HOSPITAL	BALTIMORE C	TTY N	IA
REC	10a. STATE 10b. COUNT	Y 10c. CIT	TY, TOWN OR LOCATION		10d. INSIDE CITY
	10e. STREET AND NUMBER	Jairo	130170		1 X YES 2 NO
FUNERAL	1240 She	rwood Ave	101. ZIP CODE		S. A
FUN	11. MARITAL STATUS 1 Nover Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPAI If yes, specify Guban, Maxica	NIC ORIGIN? (Specify Yea or No. 14.	RACE — American Indian, Black, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 TES 2 NO Specifi		Specify: Black
6	15. DECEDENT'S EDU (Specify only highest grad		S USUAL OCCUPATION work done during most of working	186. KIND OF BUSINESS/INDUST	TRY
E	Dementary Secondary (0-12)	College (1-4 or 5+) Ille. Do NOT u	ise retired.)	unknow	
COMPLETED	17 FATHER'S NAME (First, Middle, Last)	17 17 17 17 17 17 17 17 17 17 17 17 17 1	11010011	ME (First, Middle, Malden Surname)	<i>W</i> 5
BE C	Koger le G	rand	G-100	dus Perry	
2	19a AF ORBANT'S NAME (Type/Print)	nable 81	ADDRESS (Street and Number or Aural I	Route Number, City or Toyun, State, Zip Coo	m 1 01207
Ĺ	200 METHOD OF DISPOSITION	20b PLACE AND DATE	OF DISPOSITION (Name of	DATE 20g. LOCATION -CHY	or Town State
	1 Buriel 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from Stata gemetery, fremetory of d	pine placed Cemetery	3/3/45 Anne, An	
	21. SIGNATURE OF FUNERAL SERVICE M	CENSEE	22. NAME AND ADDRESS OF TA		
	- Jume +	t. Thompson I	19 4300 WA	bash ITVE	
	23. PART I Entar the diseases, pr shock, or haart failure.	complications that caused the daeth. Do tall to only one cause on each line.	not anter the mode of dying, suc	h aa cardiac or reepiratory arrest	interval Between
	iMMEDIATE CAUSE (Final disease or condition	liver failur	№		Onset and Death
	resulting in death)	OUE TO (OR AS A CONSEQUENCE O	OF):	- 114	- m
NO	Sequentielly list conditions,	b. hepatitis (VITUS		10 g
EA.	If any, laeding to immediata cause. Enter UNDERLYING	alcohol abu	56		154
Ĕ	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE O	F):		1.59
CERTIFICATION	resulting in death) Exst	d			
	PART II. Other significant condition	ns contributing to death but not reaulting	in the undarlying causa givan in	Part i. 24a, WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
E E	retroviral	infection		1 [] YES 2 NO	OF DEATH?
E. M	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH YE	ES NO UNCERTAIN		1 TYES 2 NO
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLACE OF OEA	TH (Check only one)		
YSIC	1 VES 2 NO	HOSPITAL: 1 Inpatiant 2 ER/Outpetlant 3 DOA	OTHER: 4 Nursing Home 5 Realdence		
	27. MANNER OF DEATH Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year) 26b. TIM	JURY 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURE	ED
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY — At home, farm, building, atc. (Specify)		281. LOCATION (Street and Number or R	Tural Route Number,
ETE	4 Homicide determined	werranty, site (opensy)		City or Town, State)	
COMPLETED		ICIAN: To the best of my knowledge, death occurr			
	29b. SASNATURE AND ATTLE OF CONTROL	ER: On the basis of examination and/or investigation			
BE	Cullin X	Klim MA	29c. LICENSE NUN	BER 29d. DATE SIG	SNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF DEATH (ITEM 27) (Type		- Par	1
	Jettrey D Re	rkins, 600 N. U	Volfe St Ba	Itimore, MD	21287
	MAR 1 3 1995	32. REGISTRAR'S DIGNATURE			

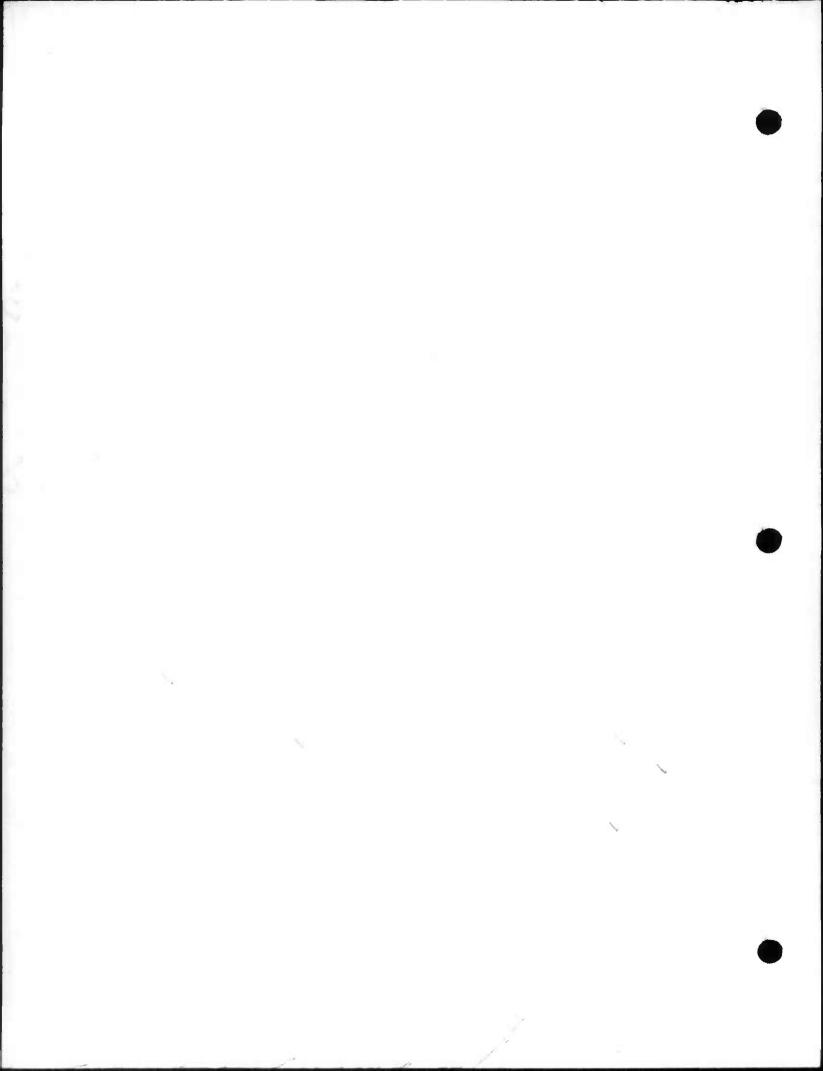
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher found in the flows after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heatth and Mental Hydrigene prior to burial, cremation, or removal. In removal and accomplished at page 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heatth and Mental Hydrigene prior to burial, cremation, or removal assuminant must be markfulled at page.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

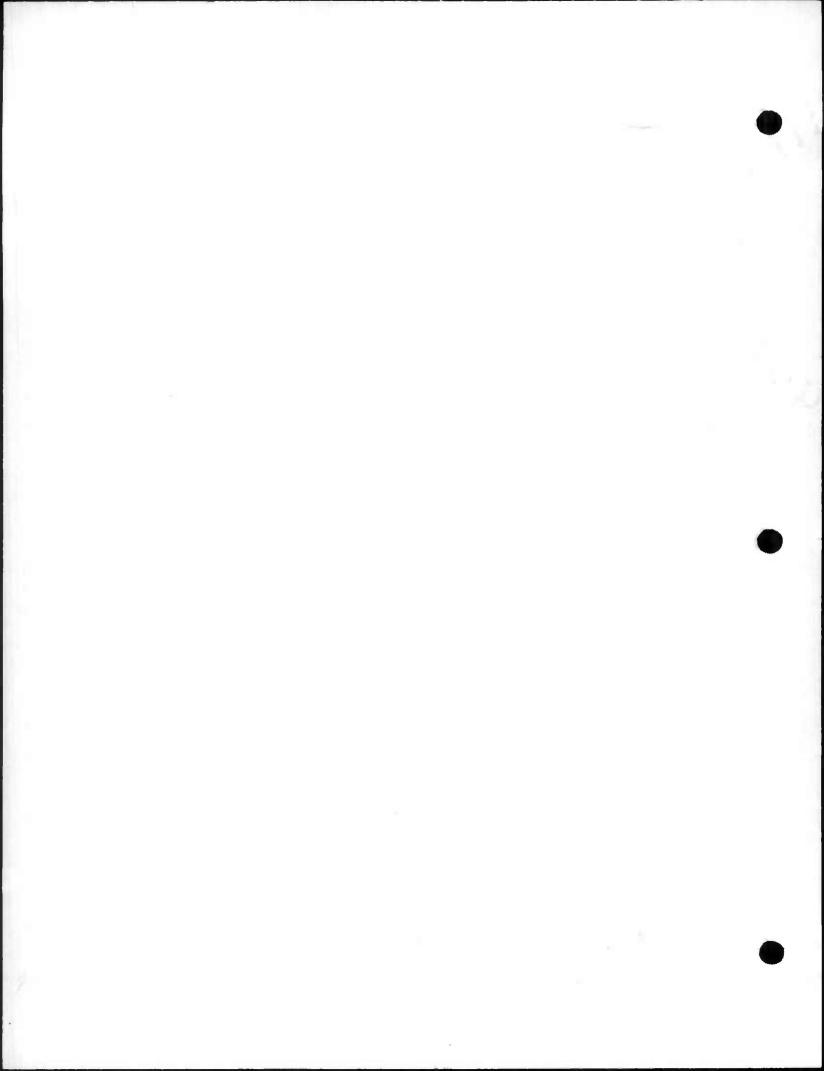
	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE MONTH	OF DEATH			3. TIME OF DEATN
			Kathry	n Win	ters		Lev	vis				1995	YEAR	8:30 A ^M
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. last		IF UNDER 1		IF UNDER		7. DATE (DF BIRTH , Day, Ybar)		B. BIRTHI Country	PLACE (State or Foreign
	226-42-7		1 🗆 M 2 😿 F	79	YRS.	MONTHS	DAYS	HOURS	MIN.		21, 1	916		ryland
_	9a. FACILITY NAME (If not in			-		9b. CITY,	TOWN C	R LOCATI	ON OF DE				ITY OF DE	EATN
DIRECTOR	715 Maiden (Choice	Ln., HV	514		Catonsville Balt						alt:	imore	
E C	10a. STATE	10b. COUNTY	1		10c. CITY,	TOWN OF	LOCAT	ION						10d. INSIDE CITY
뚭	Maryland		Baltimo	ore				Ca	aton	svil	l 1e			LIMITS?
¥	10e. STREET AND NUMBER						10f	ZIP COD				10g. CITI		HAT COUNTRY?
FUNERAL	715 Maide	n Cho	ice Lar	ne, HV	514				21	228			US	A
5	11. MARITAL STATUS	200.00	12. WAS DECEDEN	T EVER IN U.S. ABI	WED						? (Specify Yes	or No-	14. RACE	- American Indian, White, etc.
BY	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y						Specify		iican, etc.)		Specify	y:
	15. DEC	EDENT'S EDU	CATION	16a DE	CEDENT'S U	ISLIAL OC	CHIDATIC	MA .		1465	KIND OF BUS	INFOC (INC	HOTOV	White
COMPLETED	(Specify only Elementary/Secondary (0	y highest grade	completed) College (1-4 or 5	(Gi	ve kind of wo Do NOT use	ork done du	ring mo	st of working	ng	100.	KIND OF BOX	MESSIND	USTRY	
립	Lietherian y coolinan y (o	,	4		nenta	rv S	choo	1 Te	eache	r		Puh1	ic S	Schools
Š	17. FATNER'S NAME (First, M	iddie, Last)									fiddle, Maiden		10 1	JCHOO15
BE	Wil.	liam	"unkno	wn" Me	orro	W		F	Iele	n '	unkn	own"	Ca	arter
2	19a. INFORMANT'S NAME (7)										er, City or Town		Code)	
_	Wayne A.								r.					17325
	20a. METHOD OF DISPOSITI	n 3 🗆 Ram	oval from State	20b. PLACE A cemetery, crer	ND DATE OF	er plece)	ION /Na	me of	00	OATE	20c. LO	CATION —	City or Tow	en, Stata
	4 Donation 5 Other 21. SIGNATURE OF SUNERAL		ENSEE //g	Metro	Crem	ALOI 22 M	y,	Inc.	SS OF FAC	/14/5	32 B	alt1	more	e, MD
3	De	720		111-6		Cr	ema	atic	n S	ocie	ty o	f Md	.,]	Inc.
- 20			MacNabb			29	9]	Fred	leri	ck F	Road	Bal	to.,	MD 21228
- 1	23. PART I. Enter the di shock, or hi	aart fallure.	List only one car	reson each ilna.	eth. Do no	ot enter t	he mo	da of dy	ing, auct	h ss cerd	iec or reepi	ratory arr	eat,	Approximete Intarvai Between
	IMMEDIATE CAUSE (Findisease or condition	nal	, /	1	/	1								Onset and Death
	resulting in death)	→	s. DUE TO	(OR AS A CONSEC	LIENCE OF	m	9							691
_				(en no n consec	OLIVOL OI)	•								
CERTIFICATION	Sequentially list conditi		OUE TO	(OR AS A CONSEC	UENCE OF):	:								
5	cause. Enter UNDERLYi CAUSE (Disease or inju	NG	c											
	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSEC	UENCE OF)	:								
#	Tooling III doubly and		d										_	
CAL	PART II. Other significa	nt condition	a contributing to	death but not n	suiting in	tha und	eriying	ceuse g	given in l	Part I.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS
											1 YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
													- 1	1 TES 2 NO
ż	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	1 🗆				
ਠੇ	25. WAS CASE REFERRED TO EXAMINER?	D MEDICAL	HOSPITAL:		E OF DEATH	OTHER.		-						
X	1 YES 2 NO			ER/Outpetient 3					sidence	6 Other				
BY PHYSICIAN:	1 Natural 5	Pending	26a. DATE OF (Month, D	lay, Year)	26b. TIME INJU	RY	BC. INJI WO	RK?	_ NO	28d. DEŞ	CRIBE NOW II	NJURY OCC	URED	
	a Cutate	Investigation	28e. PLACE C	F INJURY — At hor	ne, farm, atr	reet, factor				281, LOCA	TION (Street a	and Number	or Rumi Ro	oute Number
COMPLETED		Could not be determined	building,	atc. (Specify)						City	or Town, State)			
ا ت	29a, CERTIFIER 1 CERT	IFYING PNYSI	CIAN: To the best of	my knowledge, dea	th occurred	Lat the tin	ne date	and place	and due	to the cau	se(s) and man	nar an elek	d	
														and manner as stated.
	256. SIGNATURIE AND TITLE	-		Contract of the					ENSE NUM					(Month, Day, Year)
BE	Valor C	Wall	wheel 6	W					2435				rch	
2	The second secon						_		- 13)	~		C C	1 1 1 1	
Į.	36. NAME AND ADDRESS OF	PERSON WH	COMPLETEO CAU	SE OF OEATH (ITEM	1 27) (Type, F	Print)								13, 1777
	William C	. Wat	erfield	1. M.D.			Ca	ton	Ave	nue	Bal	20,700		
	Section of the second section of the second	. Wat	erfield	M.D.			Ca	ton	Ave	nue	Ba1	20,700		21229





Item1,Film721,3/13/95,lt

J. GE		1 - STATE REGISTRAR	SINIE UT MA		FICATE OF	DEATH AND	MENTAL HYGIEN REG. NO					
		1. DECEDENT'S NAME (First, Middle, Last)	-				2. DATE OF DEATH		3. TIME OF DEATH			
		ESTER ESTHER		MCCOLI	LUM-EI			7,1995	17:25 P M			
*		110 00 00		AGE (In yrs. last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign			
모		011 30 3133	1 M 2	TO YAS.	MONTHS DAYS	HOURS MIN.	July 7,	1948	"ma			
pinous	~	9a. FACILITY NAME (If not institution, give stre	eet and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH			
2, 3	ECTOR	3011 WOODLAND AVE. BALTIMORE N/A										
Pages 1	iii	10d. INSION										
	5	md	1/A		12al	0			LIMITS?			
permit.	\¥	10e. STREET AND NUMBER	1 0		10	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
an. ransit	FUNERAL	3011 Woodlan	d Ave			2121	5	u	·S. A			
DZO physician. burial-transit	5	11, MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	YES 2 NO	13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Specify Yas an, Puarto Rican, etc.)	or No- 14. RAC	E - American Indian, ik, White, atc.			
	B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		2 NO Speci		Spec	"Black			
The hospital or attending detached for use as the once.	8	15. DECEDENT'S EDUCA		16a. DECEDENT	S USUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUSTRY	THE PARTY OF			
al or a	ET	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT		st of working	100000000000000000000000000000000000000	1				
AND the hospita detached	COMPL	12m	2415	W	rknown		u	nknov	^			
	00	17. FATHER'S NAME (First, Middle, Last)	, i			6	AME (First, Middle, Walden	Sumame)				
ed by ed at at		Llewelyn Di	uton			Jan	an All	1				
retained 5 should	2	199, INFORMANT'S NAME (Type/Print)	ristian	3011	O ADDRESS (Street a	1 - () ()	Route Number, City on Tow		Dine			
age of		20g.,METHOD OF DISPOSITION	113/14/1	1	WOOD	land 1	ve bact	-/	21215			
ector, p		1 Burist 2 Cremation 3 Remov	ral from State	20. PLACE AND DATE CEPTETRY, Crematory of	offer place)	PL	3/12/ - 1/	anda I	s town, md			
Page al direc		21. SIGNATORE OF FUNERAL SERVICE LICE	VSEE	7 (1. 4)		D ADDRESS OF F	CILITY	010000	3 10011,1100			
death. Pag death. Pag tuneral di l. examiner	100	Atome +	1. Min	no F	mar	ch fift	bash Au	/a				
nours after d in by the or removal		23. PART i. Enter the diseases, or co	mplications that co	USIM DR	not enter the mo	de of dulon au			I Assessed to			
		ahock, or heart fellure. Li IMMEDIATE CAUSE (Final	at only one ceuse	on eech line.	not enter the mo	de or dying, aut	in all cardiec or reepi	retory arrest,	Approximate Interval Between			
		disease or condition resulting in death) aARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										
completely rial, cremati		resulting in death) P &2	DUE TO (OF	R AS A CONSEQUENCE	CARDIC	VASCUL	AR DISEAS	E				
executed with and complet b burial, cren	Z	Sequentially list conditions, b.										
e be execute sician and confor to buria	CATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OF	R AS A CONSEQUENCE	OF):			-				
Phy phy		CAUSE (Disease or injury C.	DUE TO (OF	R AS A CONSEQUENCE ()E)·							
Agie Agie	ERTIFI	that initiated events resulting in death) LAST		THE R CONTROL OF	, ,.				Valence of			
	빙	d.										
36 4	MEDICAL	PART ii. Other aignificant conditione	contributing to de	ath but not reaulting	in the underlying	cause given in	Part i. 24s, WAS AN PERFOR	AUTOPSY 24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
w requires that been signed by pt. of Health an 3 shows any							1 🗆 YES 2	₩ NO	COMPLETION DF CAUSE DF DEATH?			
law requires as been sign lept, of Healt 23 shows		DID TOPACCO LICE CONTROL	DUITE TO CALL	T OF DEATH W					1 TYES 2 NO			
e law has be Dept.	SICIAN:	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUIE TO CAUS		ATN (Check only one)	UNCERTAI	INQU	IRY				
PHYSICIAN: The law this certificate has with the State Dep reed, or item 23	Sic		HOSPITAL:	R/Outpatient 3 🗆 DOA	OTHER:		• E • • • • • • • • • • • • • • • • • •					
PHYSICIAN: this certifica with the Str	РНҮ	27. MANNER OF DEATN	28a. DATE OF INJ	IURY 28b. TII	WE OF 28c. INJ	URY AT	6 ☐ Other (Specify) 28d, DE\$CRIBE NOW II	NJURY OCCURED				
	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	rear) IN		RK? 'ES 2 NO						
D A D .	0	3 Suicide 8 Could not be	28a. PLACE OF IN	JURY At home, ferm, (Specify)	street, factory, office	,	281. LOCATION (Street a City or Town, State)	and Number or Rural F	Route Number,			
OR ATTEN DIRECTOR: hours after item 28 i		4 Nomicide determined					Oily or lown, State)					
	COMPLE	29a. CERTIFIER 1 CERTIFYINO PNYSICIA	AN: To the best of my	knowledge, death occur	red at the time, date	and place, and due	to the cause(a) and man	iner as stated,				
HOSPITAL FUNERAL Within 72 TANT: If	S S	2 MEDICAL EXAMINER:	On the basis of axem	ination and/or investigati	on, in my opinion, d	eath occured at the	time, data and placa, an	d due to the cause(a) and manner as stated,			
HE HE HE BE WITH	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	. 11	6		29c. LICENSE NUI	MBER	29d. DATE SIGNED	(Month, Day, Year)			
TO THE HOSPIT TO THE FUNERA Be filed within 7	0	Theodie M	Kry	ny		OCME		MAR	CH 08,1995			
	-	SE NAME AND ADDRESS OF PERSON WHO										
		THEODORE KING M			REET BA	LTIMORE	E, MARYLAN	D 21201				
		31. DATE FILED (Month, Day, Year) MAR 1 3 1995	32 REGISTRAR'S	SIGNATURE								
		T 0 1999	A Pro. M. June	CONTRACTOR								



FOR STATE REGISTRAR

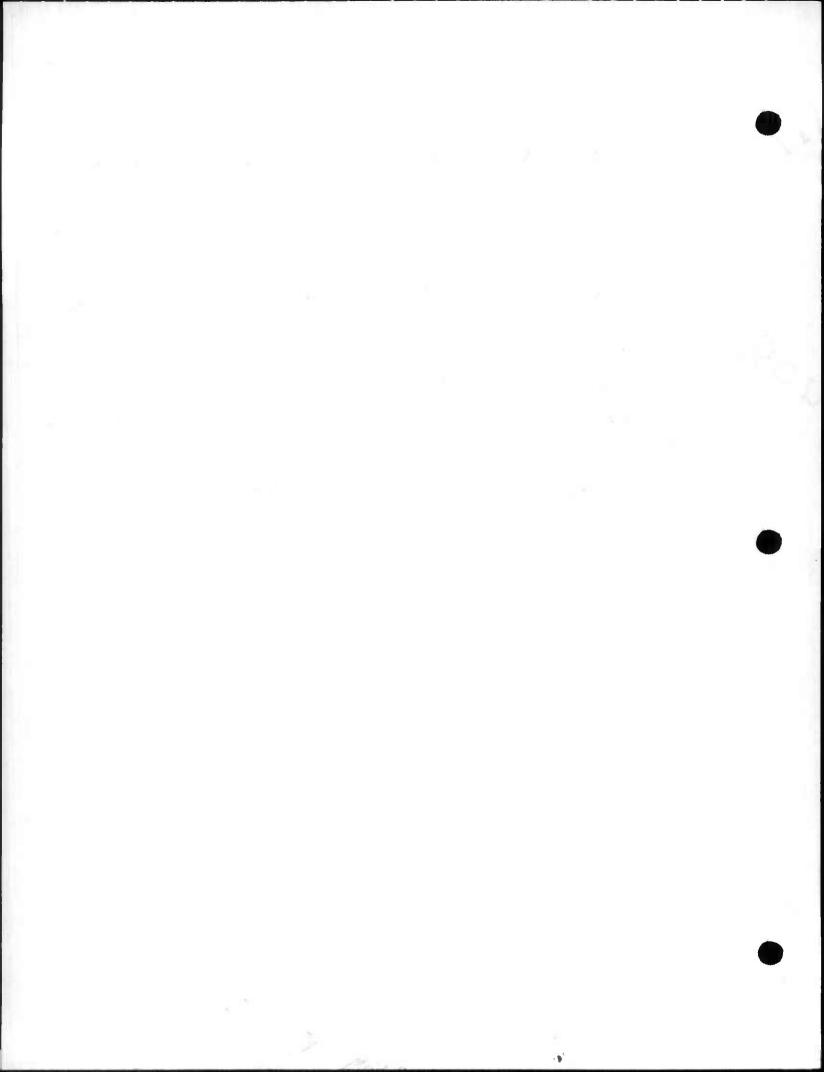
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE O	DEATH	REC	3. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) THOMAS		M	CDONAI	LD	2. DATE OF DE	DAY	YEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE ((In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR		95	8:16P M
	250-12-9304 90. FACILITY NAME (If not institution, give str	1X M 2 🗆 F 🕹	_	MONTHS DAYS	HOURS MIN.	NOV.	3, 1742 6	SREE	CE (State or Foreign
TOR	ANNE ARUNDEL CO		ITAL		VAPOLIS	EATH		NE A	RUNDEL
DIRECTOR	10e. STATE 10b. COUNTY	15.		TOWN OR LOC				100	I. INSIDE CITY
	100. STREET AND NUMBER	1=100		07/46	EVI CLE	5	100 CITIZE		YES 2 NO
FUNERAL	RT. 2 BOX	640	NILL ADMITS		2943			0.3	5.4.
BY	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, i	ECENDENT OF HISPA specify Cuben, Mexico SS 2 NO Specific	in, Puerto Rican, e	tc.)	Spacify:	American Indian, hite, etc.
	15. DECEDENT'S EDUC. (Specify only highest grade of	completed)	16e. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during n	TION nost of working	16b. KIND	OF BUSINESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	TRUCK	DRIV	ER	TR	ANSPOR	ZIAT	ion
BE CO		LER Mis			571		rock		
2	190. INFORMANT'S NAME (Type/Print) LINDA ALEXENDA	EL MCDONAL	D RT-2	BOX 6	end Number or Rural	Route Number, City			29435
	20e_METHOD OF DISPOSITION 1 Surtal 2 Cremetion 3 Remote 4 Donation 5 Other (Specify)	val from State	PLACE AND DATE OF		Name of GARDEN	OATE 2	oc. LOCATION - CI	ty or Town,	State JC ·
	21. SIGNATURE OF PUNERAL SERVICE LICE	. Skard	le f.	S/NAME	AND ADDRESS OF FA	L 28	BALTO.	MD	· 2/224
	23. PART I. Enter the diseases, a constant shock, or heart feliure. L iMMEDIATE CAUSE (Final disease or condition resulting in death)	Atheros	clerotic Consequence of					st,	Approximate interval Between Onset and Death
CALION	Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF)	:					
CERTIFICATION	CAUSE (Disease or Injury that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
EDICAL	PART II. Other aignificant conditions Obessylva	contributing to death b	ut not reaulting in	the undarlyi	ng ceuse given in	P	AS AN AUTOPSY ERFORMED? (ES 2 NO	AWA	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION DF CAUSE DEATH?
Σ ÿ	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES		UNCERTAI	N DR		10	YES 2 NO
SICIAN:		HOSPITAL:		OTHER:)				
PHY	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp 28e. DATE OF INJURY	28b. TIME	OF 28c. IN	me 5 Residence		HOW INJURY OCCU	RED	
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUI	M 1 🗆	YES 2 NO				
TED	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined 28e. PLACE OF INJURY — Al home, farm, street, lectory, office building, atc. (Specify) 28e. PLACE OF INJURY — Al home, farm, street, lectory, office building, atc. (Specify) 28e. PLACE OF INJURY — Al home, farm, street, lectory, office building, atc. (Specify)								
COMPLET		IAN: To the best of my knowl : On the basis of examination							manner ee stated.
w II	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI				nth, Day, Year)
01	Denni.	1 Cluste or	0			M.E.			1 06/95
	30. NAME AND ADDRESS OF PERSON WHO		111 PEN	N STRE	EET, BAL	TIMORE	, MARYI	AND	21201
	MAR 1 3 1995	1 32 TEBBLERS NOW	dudl						

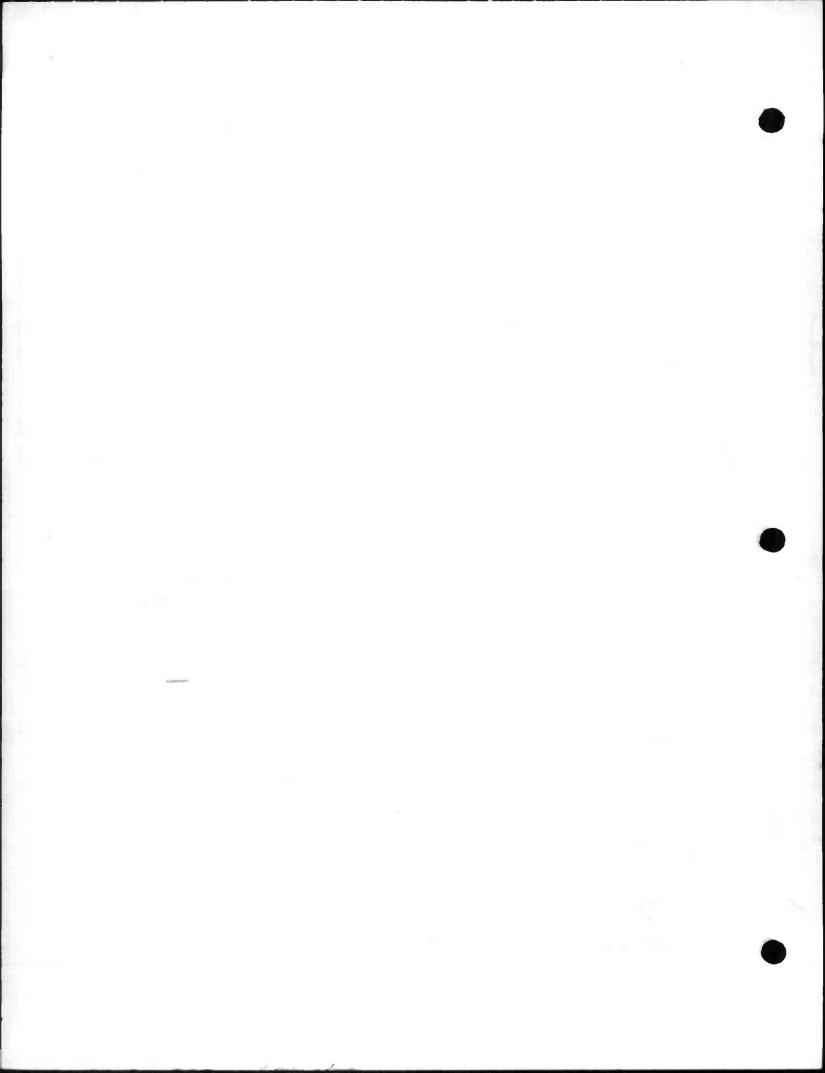
DIVISION OF VITAL RECORDS, P.O. BOX 68769

BALTIMORE, MARYLAND 21215-0020

6

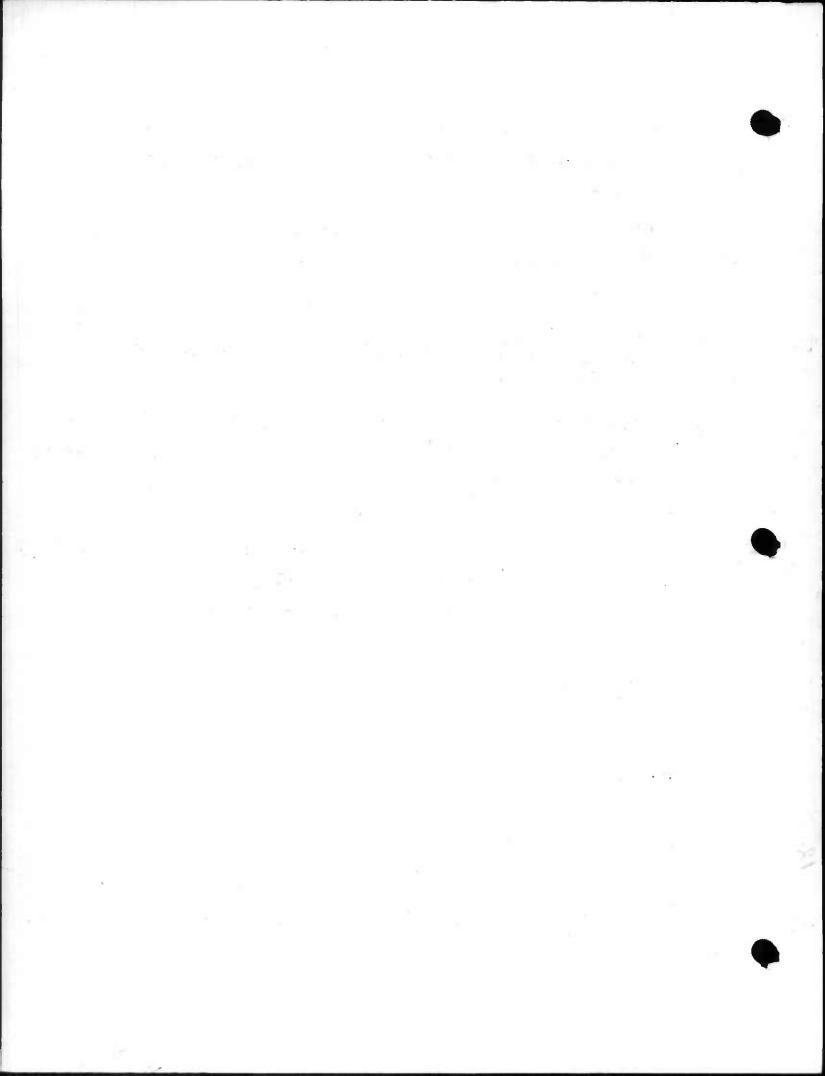


		1 - STATE OF MAR	RYLAND / DEPART CERTIFIC	MENT OF H	EALTH AND ME	NTAL HYGIENE REG. NO.				
		1. DECEDENTS NAME (First, Mickele, Last)		us	JV. 2	DATE OF DEATH DAY	7 - 9 YEAR	3. TIME OF DEATH		
3 should		218-32-0178 1 🖾 M 2 🗆 F	OU YRS.	MONTHS DAYS 9b. CITY, TOWN O	HOURS MIN.		Countr	aryland		
Pages 1, 2, 3 s	DIRECTOR	Veterans Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY,	Baltin				10d. INSIDE CITY		
permit		Maryland Talbot 10. STREET AND NUMBER		Trappe 101. ZIP CODE 10g. CITIZEN OF						
215-0020 attending physician. se as the bural-transit	BY FUNERAL	26902 ISland Creek Ne 11. MARITAL STATUS 1 Never Merried 2 (X) Merried 3 Widowed 4 Divorced 2 State of the control of the co	ER IN U.S. ARMED YES 2 NO		city Guban, Maxican, P	ORIGIN? (Specify Yes or uerto Rican, etc.)	No- 14. RACE Black Speci	E — American Indian, k, White, atc.		
or aff	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of wo	I.a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retried.) 18b. KIND OF BUSINESS/INDUSTRY						
by the hospital be detached to at once.	101	12 17. FATHER'S NAME (First, Micolie, Last) Robert V. McManus Sr.	Rest	orer	18. MOTNER'S NAME Regina	Boats (First, Middle, Maiden Sur MC(
MAR retained 5 should notified	TO BE	194. INFORMANT'S NAME (Type/Print) Margaret Jane McManus	196. MAILING A	ADDRESS (Street ar		Number, City or Town, S				
death. Page 6 may be tuneral director, page 6.		20a. METHOD OF DISPOSITION 1 Surial 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE LICENSEE	20b. PLACE AND DATE OF cometery, cremetory or othe Metro Cre	er place) INATORY 22. NAME AN	Inc.	3/13 Bali	timore,	Maryland		
urs after in by the r removal		23. PART I. Enter the diseases, or complications that our shock, or heart failure. List pnly one cause o	used the death. Do no	31111	ings Funer <u>Mountain</u> ^{Se of dying, auch ac}	Rd. Pasade	ena, Md.	21122 Approximate Interval Batween		
in 24 fille		IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR /	AS A CONSEQUENCE OF:	1 =	comple	Me Key	5	Onest and Death		
Los, P.C. BOX 68/60) The death certificate be executed with the attending physician and complete Mental Hygiene prior to burial, cren niury, or other traumatic event	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	AS A CONSEQUENCE OF):	D.C.	APPRO	VED-OC	ME			
signed by the Health and M	MEDICAL	PART II. Other algnificant conditions contributing to deat			cause given in Par	24a, WAS AN AUT PERFORME 1 X YES	D?	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES NO		
SICIAN: The law requestificate has been the State Dept. of 1, or item 23 sho	PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 (1) YES 2 NO NO Input lant 2 ER/C	26. PLACE OF DEATH	(Check only one)	UNCERTAIN [
F in F	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Yee 2 Accident Investigation	RY 28b. TIME INJUR	OF 28c. INJU WOR 1 YI	ES 2 NO	LDESCRIBE NOW, INJU	cp. tal	(c6 hx		
E ME ME	PLETED	4 Homicide determined building, etc/(3	Imore UA	hesp	i for 1	City or Jown, State)	St C	Sulfue Q		
TO THE HOSPITAL TO THE FUNERAL be filed within 72 P	BE COM	one) = MEDICAL EXAMINER: On the basis of examina		in my opinion, de		, data and place, and de	us to the cales(s)	(Marth, Day Year)		
05 05 Mi	5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	· Green	1	- Rul	+ mo	2120	ر (۹۵		
		MAR 1 3 1995 July Day Day Day	Mardell .							



FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIE	NE
REGISTRAR	CERTIFICATE OF DEATH REG. NO	Э.

		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.
		1. DECEDENT'S NAME (First, Migdin, List) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH
		BOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. Isial birthday) F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign
9		062051524- 1XM 2 - F 79 YRS. MONTHS DAYS HOURS MIN. Sept 4 1915 COUNTY)
3 should	Œ	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH
1, 2,	010	OINAI HOSP. BALTIMORE
Pages	DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS 1 DIVING 2 NO
permit.	AL C	100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY?
ust.	FUNER	78-6179 HANE 11358 U.S.A.
020 physician. bunial-transit		11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, 15. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 16. RACE — American Indian, 17. Black, White, atc. 17. YES 2 NO Specify: 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. RACE — American Indian, 19. RACE — American Indian, 19. RACE — American Indian, 11. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. RACE — American Indian, 11. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, 15. RACE — American Indian, 16. RACE — American Indian, 17. RACE — American Indian, 18. RACE — American Indian, 19.
nding the	D BY	3 Wildowed 4 Divorced
2121 al or atte	ETE	15. DECEDENT'S COUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION (Gave kind work done during most of working) 16b. KINO OF BUSINESS/INDUSTRY (Gave kind working) 16c. OECEDENT'S USUAL OCCUPATION (Gave kind working) 16c. OECEDENT'
ND 2 hospital ached to	COMPL	12 CLERK NEWYORK CITY
YLAND 212- by the hospital or att be detached for use at once.		17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meidell Surname) ANNA ENGLELT
MARYLAND retained by the hospit should be detached notified at once.	38 C	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	5	FLORENCE NAGEL 78-6179 LANE GLENDALE, N.Y-1/358
6 ma etor, p		20b. METHOD OF DISPOSITION 1 Surial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of configurations) 20b. PLACE AND DATE OF DISPOSITION (Name of configurations) 20c. LOCATION — Give or Town, State
ALTIMO death. Page tuneral direct.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY RALTO, 100. 21224
8 4 8		Thomas J. Starda F. H. 2829 HUDSED ST.
urs aft in by r remo		23. PART I. Enter the diseases, o complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart failure. List only one cause on each line.
₩ 8 B		IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardiodenic Shock 3 days
N 2 5 - 6		OUE TO (OR AS A CONSEQUENCE OF):
execute and to bur to bur matin	NO.	Sequentially list conditions, out to (or as a consequence of): Sequentially list conditions Sequentially list condition
m = >	ICAT	CAUSE (Disease or Injury C. Ruptured Septum
Certing Hygie	CERTIFICATION	that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST
S, F death death e atte femtal		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PINDINGS
and and a	ICAL	PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE
w requires that been signed by to it Health an shows any	MED	1 YES 2 NO OF DEATH? 1 YES 2 NO
OF VITAL RECO HYSICIAN: The law requires this certificate has been signed with the State Dept. of Health ked, or Item 23 shows at	SICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)
VISION OF VITAL I ATTENDING PHYSICIAN: The law ECTOR: After this certificate has b s after death with the State Dept. 28 is marked, or item 23	SICI	25. PLACE OF DEATH (Check only one) EXAMINER? 1 VES 2 NO 1 No SPITAL: 1 NO SPITAL: 1 NO SPITA
OF V PHYSICIAL this certif with the	PHY	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. 0ESCRIBE HOW INJURY OCCUREO
SION OF TENDING PHYS OR: After this of frer death with 18 Is marked,	D BY	2 Accident Investigation 3 Suicide 8 Could not 288. PLACE OF INJURY — At home, ferm, street, factory, office 281, LOCATION (Street and Number or Rural Poune Number)
DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETEC	4 Homlelde determined building, stc. (Specify) City or Town, State)
DIVI:	COMPLI	29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as attend.
HOSPI FUNER within		2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner se stated. 29b. INVESTIGATION OF THE OF CRAFFINE MANNER
TO THE HOSPITAL (TO THE FUNERAL D De filed within 72 h IMPORTANT: If It) BE	296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your)
	5	30. NAV. AND ADDRESS OF PER ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Syps., Print)
Li .		31. DATE FILED (Month, Day, Ybar) 32. REGISTRAR'S SIGNATURE
		MAR 1 3 1995 July d'avolson Rardall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumade event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

	TEGIOTIAN			_			CALL		DLA	111	REG. N	0.		
	1. DECEDENT'S NAME (First	t, Middle, Last)									2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
		Patrio	ck J. C.	Pet	r						March 8	199	5	5 4 H
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE ('in yrs. last i	birthday)	IF UNDER	1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	219-40-6468	3	1 💢 M 2 🗌 F		51	YRS.	MONTHS	DAYS	HOURS	Min.	3/19/194	3	Count	vland
	9e. FACILITY NAME (If not in		treet and number)				9b. CITY	TOWN (OR LOCAT	ON OF DEA		_	UNTY OF D	V
E	St Toponh	Hoens	1+21									30.00		imore
DIRECTOR	St. Joseph	CEDENT	LLai					101	vson				Dait	THOLE
ĬŽ.	10a. STATE	10b. COUNT	Y			10c. CIT	, TOWN	OR LOCAT	TION					10d. INSIDE CITY
ā	Maryland						Balt	imor	9					LIMITS?
7	10e. STREET AND NUMBER			-			54.0	_	. ZIP COD	E		10a, Cl	TIZEN OF V	WHAT COUNTRY?
FUNERAL	3802 Fran	kford	Avenue						212	06				States
3	11. MARITAL STATUS		12. WAS DECEDEN	T EVER II	N U.S. ARM	ED	13	WAS DEC			C ORIGIN? (Specify			E — American Indian,
	1 Never Merried 2 🔀	Married	FORCES? 1 IF YES, GIVE V	YES	2 NO			if yes, sp	ecify Cubi	n, Maxican	Puerto Rican, etc.)	98 OF 140-	Biaci	k, White, etc.
BY	3 Widowed 4 Divo	prood	1961-19	64	AIES			I 🗌 YES	2 X NO	Specify:			Speci	" ^{y:} White
8	15. DEC	EDENT'S EDU	CATION		16s. DECI	EDENT'S	USUAL O	CCUPATIO	ON		16b. KIND OF E	USINESS/IN	DUSTRY	
E	(Specify onl	ly highest grade	College (1-4 or 6		(G/ve	e kind of v	vork done e e retired.)	during mo	st of world	ng		001112007111		
립	12	5-12)	College (1-4 br 6	"	Р1	lann	er/F	stim	ator		Hos	pital		
COMPLET	17. FATHER'S NAME (First, M	fiddle Last)				-		3 0 1 11			E (First, Middle, Mald		_	
		rd Pet	r								thy Linze	,		
B	19s. INFORMANT'S NAME (.1	_	404	****						•		
2	Mrs. Shar		Dotw		190.						oute Number, City or 1			21206
2	20s. METHOD OF DISPOSIT		retr	1		_				Aver		imore	_	
É	1 X Buriel 2 - Cremetic	on 3 🗆 Rem	oval from State	20b. cem	PLACE AN	atory or of	of DISPOS her placel	ITION (Na	me of	_	DATE 20c.	OCATION -	-	
	4 Donation 5 Other 21. SIGNATURE OF FUNERA		THE TAIL								/11/95	<u>Balti</u>	more	, Maryland
	21. SIGNATURE OF FURERA	A SERVICE LIC		kΤ.	Zavo	oyna				SS OF FACE	urv ICK, Inc.			
8	Mag	41.1	Separa	-							Road Ba]+imo	ro I	Md. 21214
	23. PART i. Enter the d	Iseases, or o	omplications the	t caused	the deat	th. Do n	ot anter	the mo	de Df dv	Ing. such	as cardiac or res	piratory a	rest	Approximeta
	anock, or n	esit fellure.	List only one cau	ee on e	ech Ilne.								1.55	Interval Between
	IMMEDIATE CAUSE (Fir disease or condition	nel	12 1		1/ -	+	M.	/		1.1	. C			Onset and Death
	resulting in death)	7	a.dydle	000	CONSEQU	100					1550012			
			FILE)	CONSECU): 	-0	-	1	seending	-		44 - 4 -
l o	Sequentially list conditi	ions,	DUE TO	OR AS A	CONSECU	IFACE OF	467	ונף	perio	V 01.	seending	Corus	idry.	HXTONY
¥	If any, leading to imme- cause. Enter UNDERLYI		Mula			,	,-						-	
1 12	CAUSE (Disease or Inju	iry	DUE TO	(OR AS A	CONSEQU	JENCE OF	1:							
E	resulting in death) LAS	т	Sein		1.			7-		\				j
CERTIFICATION		-	d.	Y-R-(676	ים ניכב			, -	DISE				<u> </u>
	PART II. Other significe	nt condition	s contributing to	deeth b	ut not rec	eulting i	n the un	derlying	cause (given in P	art I. 24s. WAS /	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL	Di	abo 7	es Mei	1/ta	5,						PERF 1 □ YES-	PRMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
B	4	1 1	1 0	- 4							_ '	2 NO		OF DEATH?
≥	DID TOBACCO U	SE CONTI	PIRLITE TO CA	IISE O	E DEATI	U VE	сПэ	IO F	LINIC	ERTAIN				1 DIES 2 INO
A	25. WAS CASE REFERRED TO		CIDOTE TO CA		28. PLACE				UNC	EKIAIN				
PHYSICIAN:	EXAMINER?		HOSPITAL:				OTHER	t:	(2)					
] ≱	27. MANNER OF DEATH		1 Department 2 28a. DATE OF	_							Other (Specify)			
		Pending	(Month, D	ey, Year)	_ [28b. TIMI	JRY		RK?		28d. DESCRIBE HOV	INJURY OC	CURED	1 1.
BY	2 Accident	Investigation	3-8	-75			M	1 🗆 ۱		NO	Duxin	a loca	MANY	Angu LasTr
<u>.</u>		Could not be determined	28s. PLACE O building,	etc. (Spec	— At home	e, farm, s	treet, fact	ory, office	1		281. LOCATION (Street City or Town, Sta	and Numbe	r or Rumil A	Noute Number,
		- Jan Miller	A	25/1	75/	Obe	raT.	ng	Rea	m	7.5	003	ork	Al Tourson
F	29s. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowl	edge, deati	h occurre	d at the ti	me, data	and place	, and due to	the cause(s) and m	enner se sta	nted.	
COMPLETED) and manner as stated.
Ш	29b. SIONATURE AND TITLE				17	-				NSE NUMB		_		(Month, Day, Year)
	10 hour	C.T.	Orlen	nes	ele	Pro		_	1	110-	83	N	3-10	
일	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	E OF DE	ATH (ITEM :	27) (Type.	Print)		<u>v</u> -	073				
	Charlock	EDI	maralell	nin	- 11 1	2	1.1.	1.	-1	/	30	well	17/	10/2/2 PUL
	31. DATE FILED (Month, Day,	Ybar)	32. REGISTRA	R'S SIGN	ATURE	5)	407	pe	1-1	PUSE	2/1/2	Dm.	18/19	11/16
	MAR 1 3 190	_ /	in Dhudson	Rand	all.			/						
		JJ ju												

BALTIMORE, MARYLAND 21215-0020

OF VITAL RECORDS, P.O. BOX 68760

	DIVISION
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X	

,								9	5 0/554			
		REGISTRAR	STATE OF MARYLAN		TMENT OF I		MENTAL HYGIEN REG. NO					
		1. DECEDENT'S NAME (First, Middle, Last) Herbert	1995	year 3. TIME OF DEATH 9 p.m. M								
ъ			SEX 6. AGE (In y)	rs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov. 4, 190		BIRTHPLACE (State or Foreign Country) Germany			
2, 3 shoul	O.B.	9a. FACILITY NAME (If not institution, give stree 609 Pleasant Hil				OR LOCATION OF DI		9c. COUNT	y of DEATH			
Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY Md. Baltin	lore		TOWN OR LOCA				10d. INSIDE CITY LIMITS?			
sit permit.		10e. STREET AND NUMBER 609 Pleasant I				H. ZIP CODE 21117	, ,	10g. CITIZE	1 ☐ YES 2 ☐XNO EN OF WHAT COUNTRY?			
physician. buriat-transit permit. Pages 1, 2, 3 should	FUNERAL	11. MARITAL STATUS 1 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO	If yes, s	CENDENT OF HISPAN	NIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.)	or No 1-	U.S.A. 4. RACE — American Indian, Black, White, atc.			
be retained by the hospital or attending physician. ge 5 should be detached for use as the buriat-trate notified at once.	red BY	3 Ni Widowed 4 Divorced 15. DECEOENT'S EDUCAT (Specify only highest grade co	ION 16	. DECEDENT'S U	JSUAL OCCUPATI	ON	16b. KIND OF BUS	SINESS/INDUS	SpecifyWhite			
ched for u	COMPLET		College (1-4 or 5+)	life. Do NOT use	enance			Machir	nery			
d by the horid be detach	BE CO	17. FATHER'S NAME (First, Middle, Last) Walter	Pawliko	wski			ME (First, Middle, Maiden NKNOWN	Sumame)				
ay be retained page 5 should be notified	TO	194. INFORMANT'S NAME (Type/Print) Klara E. Kromm					Rd., Owings		ode) 8, Md. 21117			
director, pa	0.04	20a. METHOD OF DISPOSITION 1 Buriel 2 Commetted 3 Remove 4 Donation 5 Other (Specify)			remator	y March	10. 1995 B	altimo	or Town, State			
death. Pag I funeral di I. examiner		21. SIGNATURE OF WHIRRAL SERVICE LICEN	a ch		Eckha Eckha	rdt Fune:	ral Chapel		21117			
within 24 hours after death. Page 6 may npietely filled in by the human director, par cremation, or removal.		23. PART i. Entay the disesses, or con ahook, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition	t only one cause on each	iina.	ot anter tha mo	oda of dying, suc	h as cardiac or respi	ratory arres	t, Approximate Interval Batween Onset and Death			
B 2 - 0	N	DUE TO (OR AS A CONSEQUENCE OF): Congestive heart Cailure 31/27										
ificate be execut physician and c ne prior to buris her traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury										
death certificate attending phys antal Hygiene p	CERTIF	that initiated events resulting in death) LAST	OUE TO (OR AS A CO	NSEOUENCE OF)	i:							
that the ned by the the and Me	MEDICAL	PART II. Other significant conditions of	ontributing to death but n	not resulting in	tha undariyin	g cause given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AWILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
e law requires has been sign Dept. of Hea n 23 shows	SICIAN: M	DID TOBACCO USE CONTRIE			NO [UNCERTAIN	v 🗆		1 NES 2 NO			
SICIAN: The certificate the State the State	PHYSIC	EXAMINER?	OSPITAL: Inpetient 2 ER/Outpetier 28a. DATE OF INJURY		OTHER: 4 - Nursing Hon	Ne 5 Residence						
DING PHYS After this death with	BY	1 Netural 5 Pending 2 Accident investigation	(Month, Day, Year) 28e. PLACE OF INJURY — A	INJU	M 1	YES 2 NO	28d, DESCRIBE NOW INJURY OCCURED 28f, LOCATION (Street and Number or Rural Route Number					
OR ATTEND DIRECTOR: / hours after d item 28 is	LETED	4 Homicide datarmined	building, atc. (Specify)				City or Town, State)					
IOSPITAL (UNERAL D VITHIN 72 h ANT: If II	COMPL	(Check only one) 2 MEDICAL EXAMINER:	N: To the best of my knowledge On the basis of examination and						cause(a) and manner as stated,			
TO THE HOSPI TO THE FUNES De filed within IMPORTANT:	O BE	29b. SIGNATURE AND TITLE OF CERTIFIER P. N	N ND			29c. LICENSE NUN			IGNED (Month, Day, Year)			

MM MD

2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

mond 1645 Liberty 21784 Eldersbur MD

July 3 registrates conjune

 BALTIMORE, MARYLAND 21215-0020

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

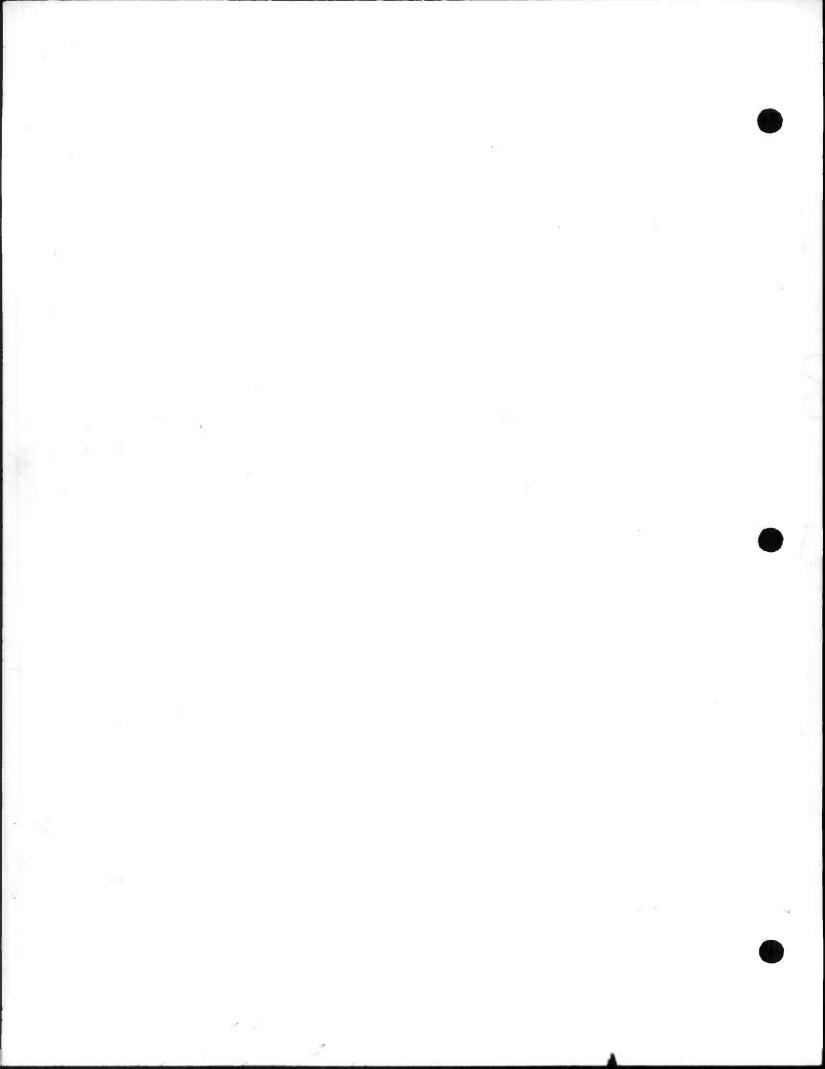
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR	CF	ERTIFICATE	OF DEATH	REG. NO		
1. DECEDENT'S NAME (First, Middle, Lest)	: 150 A A	0.500		2. DATE OF DEATH	AY YEA	3. TIME OF DEATH
4 88844 0784474444	VERA A.	PITTS		MARCH-I	0 - 95	13.24 "
and the second s	5. SEX 6. AGE (In yrs. las		YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	_ Co	IRTHPLACE (State or Foreign
9e. FACILITY NAME (If not institution, give street			OWN OR LOCATION OF D	6-29-		WP
	SPITAL		VDALLS T		BAL	TIMORE
100. STATE 106. COUNTY		10c. CITY, TOWN OR	LOCATION			10d. INSIDE CITY
MD BAC	TIMORE	BALT	imore			1 TYES 2 NO
10e. STREET AND NUMBER	D 0 ++-	- /	10f. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?
11. MARITAL STATUS	, road 5	Cle	2120		4.	5.4.
1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 - YES 2 N IF YES, GIVE WAR OR DATES	VO If y	S DECENDENT OF HISPA 18, specify Cuben, Mexico YES 2 NO Specif	an, Puerto Rican, atc.)	8	IACE — American Indian, Hack, White, atc.
15. DECEDENT'S EDUCAT (Specify only highest grade co	empleted) (Gi	CEDENT'S USUAL OCCU	JPATION na most of working	16b. KIND OF BU	SINESS/INDUSTR	
		Do NOT use prefired.)	ng most of northing	I.R.	5.	
17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NA	AME (First, Middle, Maiden	Surname)	
Edward S. A:	LOP		DAIS	Y HILL		
190. INFORMANT'S NAME (Type/Print) HILLA A. CO	2 rter 2	-909 Fa	treet and Number or Rural	Route Number, City or Tow	n, State, Zip Code,	to Md 21209
20s. METHOD OF DISPOSITION 1 D Burlat 2 Cremation 3 D Remove	of from State cometery, cree	AND DATE OF DISPOSITIO		DATE FOR LO	CATION City o	r Town, State
4 Donation 15 Other (Specify) 21. BIGHATURE OF FUNERAL BERVICE LICEN	A MET	KO CKEMA	ME AND ADDRESS OF FA	1951	a 140.	Ma.
1 Alone	H. Thompsu		ARCH FUN	beral Hon	bre of	est 51512
23. PART I. Enter the diseases, or con	mplications that caused the dest only one cause on each line.	ath. Do not anter the	a mode of dying, suc	th as cardiac or reapi	iratory arreat,	Approximate
IMMEDIATE CAUSE (Final			•			intarval Batween Onset and Death
disease or condition resulting in death)	CONGESTIVE !		FAILURE			H DAYS
_	DUE TO (OR AS A CONSEC	DUENCE OF):				
Sequentially list conditions, if any, leeding to immediate	DUE TO (DR AS A CONSEC	DUENCE OF):				
CAUSE (Disease or Injury						
that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEO	DUENCE OF):				
d						
PART II. Other significent conditions			riying ceuse given in	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
META STATIC	BREAST CA	INCER		1 YES 2	(I) NO	COMPLETION OF CAUSE OF DEATH?
DID TORACCO LICE CONTRI	DUTE TO CAUCE OF DEAT	TIL VEG 5 14				1 - YES 2 - LINO
DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL		E OF DEATH (Check only		N L J		
	OSPITAL:	OTHER:	Home 5 - Residence	8 C Other (Specify)		
27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		c. INJURY AT WORK?	28d, DESCRIBE HOW II	NJURY OCCURED	,
1 Natural 5 Pending 2 Accident Investigation		M 1	YES 2 NO			
3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At hor building, etc. (Specify)	me, term, atreet, fectory,	office	281. LOCATION (Street e City or Town, Stete)	and Number or Run	al Route Number,
290. CERTIFIER (Check only	N: To the best of my knowledge, des	ath occurred at the time,	date end place, end due	to the cause(e) end man	ner ee stated.	
	On the beele of examination end/or in					He(s) end manner ee stated.
29b. SIGNATURE AND TITLE OF CERTIFIER			29c, LICENSE NUI		29d. DATE SIGN	IED (Month, Day, Year)
those than	LOOL MD		D451	05	▶ 3	0 95
AFROZE MUNEE	COMPLETED CAUSE OF DEATH (ITEM R, 5401 01)	(Type, Print)	RD, RA	NDAUST	OWN	MD 21133
MAR 1 3 1995	32. REGISTRAR'S SIGNATURE					



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07556 95

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfiled at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Item # 1 Film # G 721 3-13-95 N.A. Per funeral home
ITEMS: 23 PART I,27,28a,b,c,d,e,f PER MEO G-722 4/6/95 reb
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I

	1 - STATE REGISTRAR		CE		CATE OF			MENIAL ATGIE!				
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEATH	NAV.	VEAD	3. TIME OF D	EATH
	CARL	В.	RAMS	SEY	Jr.			MARCH 05	19	95	7:32	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last		IF UNDER 1 YEAR MONTHS DAYS	IF UNDE	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH	PLACE (State o	r Foreign
	249-06-9151	1 X M 2 🗆 F	39	YRS.				DEC 24	955	AND	ERSON	S.C.
OC.	98. FACILITY NAME (If not institution, give 7803 HETHERT)				96. CITY, TOWN		ON OF DI	EATH		INTY OF D		
<u> </u>	7803 HETHERTO	ON LANE			POTOM	IAC_			MO	NTGO.	MERY	
DIRECTOR	10a. STATE 10b. COUNT	гү		10c. CIT	, TOWN OR LOCA	TION	-				10d. INSIDE C	ITY
	MD. Moi	UTGOME	W	P	STOMA	C					1 YES 2	□ NO
FUNERAL	100. STREET AND NUMBER		J		10	. ZIP COD	E		10g. CIT	IZEN OF W	HAT COUNTRY	7
Ü	1803 HEATH	ELJON				20	85	4	U	. 3.1	4.	
J.F.	11. MARITAL STATUS 1 Never Married 2 Married	FORCES?	T EVER IN U.S. ARN	NED D	13. WAS DE	CENDENT (OF HISPAN	NIC ORIGIN? (Specify Years, Puerto Rican, atc.)	s or No—	14. RACE Black	- American I White, etc.	ndlan,
B≼	3 Widowed 4 Divorced	IF YES, GIVE Y	MAR OR DATES		1 TYES	2 NO	Specify	y:		Specif	Line	
ETED	15. DECEDENT'S EDU				USUAL OCCUPATI			16b. KIND OF BU	SINESS/IN	DUSTRY	111-	
14	(Specify only highest grad	College (1-4 or 5	Man I	o kind of w Do NOT us	rork done during me a ratired.)	ost of working	קי	./				
COMPL	12	5+	PE	DRA	TRIC PI	4151	CAN) Hos	pil	AL		
8	17. FATHER'S NAME (First, Middle, Lest)	10	A			18. MOT	HER'S NA	ME (First, Middle, Melder	Surname)			
H	19a. INFORMANT'S NAME (Type/Print)	SEY JI	٧,				IRE	SIPIR C	07/11	CAN	_	
2	SHED! ENVM	U RAMSI		PAR PAR	ADDRESS (Street	and Number	or Rural I	Route Number, City or Toy	n, State, Zi	p Code)		
	20g, METHOD OF DISPOSITION		/	NDDATEC	F DISPOSITION (N	2481	U 1	11NC 10.	CATION -	City or Tox	MD.	
	1 Burial 2 Cremation 3 Ran	noval from State	centery crem	atory or	Hoals	BANTI	ST	# 75	FAIV	LILE	Co S	.c.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE //	11	/~ -/	22. NAME A	ND ADDRE	SS OF FA	CILITY	17D.	LIN	20,0	716
	De Chruss	Aka	upa y.		SKA	RDA	EH	4 2/29	dhin	(0.4)	7	
	23. PART I. Enter the diseases, or	omplications the	t coused the dea	th. Do n	ot enter the mo	de of dy	ing, auci	h es cardisc or resp	iretory sr	reat.	Approx	mete
	ahock, or heert fellum. IMMEDIATE CAUSE (Finel	List only one cer	ise on each line.				7-				Interval	Between and Death
	disease or condition resulting in death)	NARCO	TIC INTOXI	CATIO	N							
		DUE TO	(OR AS A CONSECU	JENCE OF):							
N	Sequentially list conditions,	b										
AT	If sny, leeding to immediate cause. Enter UNDERLYING	DUE 10	(OR AS A CONSEOU	JENCE OF):							
윤	CAUSE (Disease or Injury that initiated events	oue to	(OR AS A CONSEQU	JENCE OF):							
CERTIFICATION	resulting in desth) LAST	d									ļ	
	PART II. Other eignificent condition	na contributing to	death but not so	eultlan i	a the wederlyle		67.20		4		1	
DICAL	The significant contains	tona batting to	deeth but not re	sulling II	i the underlyin	g cause (given in	PERFOI	RMED?		WERE AUTOPSY MAJLABLE PRIC COMPLETION O	OF TO
MED								1 YES :	! □ NO		OF DEATH?	
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEAT	H YE	S I NO I	1 UNC	ERTAIN				1 YES 2) NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				H (Check only one)	0140	LNIAH	101				
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA	OTHER:	e 5 X Re	sidenca	8 Other (Specify)				
E	27. MANNER OF DEATH	28a. OATE OF (Month, D		28b. TIME	OF a 28c, INJ			28d. DESCRIBE HOW	NJURY OC	CURED		
B	1 Natural S Tending 2 Accident Investigation	3/5/95		7:3	2 M 1 🗆	YES 2	NO	UNKNOWN				
	3 Suicide 6 Could not be determined	building,	F INJURY — At hom atc. (Specify)	e, farm, si	reet, factory, offic	•		28f. LOCATION (Street City or Town, State)	7803	or Rural Ro	Oute Number,	F
E	DA CONTURAD	FOUND:						POTOMAC, MON	GUMER	Y CO.	, MB.	_
AP I	29a. CERTIFIER (Check only one) 257.3450.001. EVALUATION	ICIAN: To the best of	my knowledge, deat	h occurre	d at the time, date	and place,	and dua	to the cause(a) and mai	nner aa ata	ted.		
COMPLETE	2X XMEDICAL EXAMINE		xamination end/or in	veatigation	i, in my opinion, d	eath occur	ed at the	time, data and place, ar	d due to th	ne cause(a)	and manner e	stated.
BE	MATURE AND TITLE OF CERTIFIE	1/ 11					NSE NUM				(Month, Day, Yea	
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUS	RE OF DEATH STEEL	27) (%	(hrint)	0.0	.М.	Ei •	MA.A	KCH	06,19	195
	YAYUNA ION N	KMS.				EET.	BAT.	TIMORE, M.	ARYI	AND	21201	
1 8	31. DATE FILED (Month, Day, Year) MAR 1 3 1995	34. REGISTRA	R'S SIGNATURE		3210					7114D	- 1 2 V J	

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DIVISION OF VITAL RECORDS, P.O. BOA 86789	20	_
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	hysician.	
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.		

FUNERAL

BY

COMPLETED

BE

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

XXYES 2 NO

27. MANNER OF DEATH

Accident

1 Natural

3 Suicide

4 Homicide 29e. CERTIFIER

Item1, Film721, 3/13/95, lt FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH ROBERTSON 3. TIME OF DEATN LEMUEL ROBERSON MAR. 95 4:20 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 212-32-6488 1 M 2 | 1 DAYS HOURS 600 1934 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6819 RICHARDSON ROAD WOODLAWN BALTIMORE 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ma Da Woodlawn 1 YES 2 NO 101. ZIP CODE 21207 10e. STREET AND NUMBER 6819 Rd 10g. CITIZEN OF WHAT COUNTRY? Kichardson I.S. A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Caben, Mexicen, Puerto Ricen, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Black 3 Widowed 4 Divorced 15. OECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5+) Vestinghouse unknown 6 Yrs 17. PATNER'S, NAME (First, Middle, Last) 18 MOTHER'S NAME (First, Middle, Maiden Surname) Garland obert sur DY.12 INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, 21216 231 ara Obertson inches (10. 29a METHOD OF DISPOSITION BATE 3/11/08 PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State creminary or other place) Mem Laurel 5 Other (Specify) mol 22. NAME AND ADDRESS OF FACILITY
March Fit-West 21. SIGNATUR OF FUNERAL SERVICE LICENSEE JR 4300 Ave 1me moson Wabash 23. PART I finter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition ARTERIOSCUEROTIC CARPIOVASCULAR DISEASE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the undarlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 | NO 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

26. PLACE OF DEATH (Check only one)

HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 26a. DATE OF INJURY (Month, Day, Year)

ng Nome XIXResidence 8 □ Other (Specify) 28b. TIME OF INJURY 28c. INJURY AT WORK?

28d. OEȘCRIBE HOW INJURY OCCUREO 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, straet, fectory, offica building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)

1 CERTIFYING PNYSICIAN: To the beet of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 MEDICAL EXAMINER: On the and/or investigation, in my opinion, death occured at the time, dete end place, end due to the ceuse(s) end menner as stated,

SIGNATURE AND TITLE OF LERTIS

29c. LICENSE NUMBER O.C.M.E 29d. DATE SIGNED (Month, Day, Year) MARCH 9,1995

30. NAME AND ADDIESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

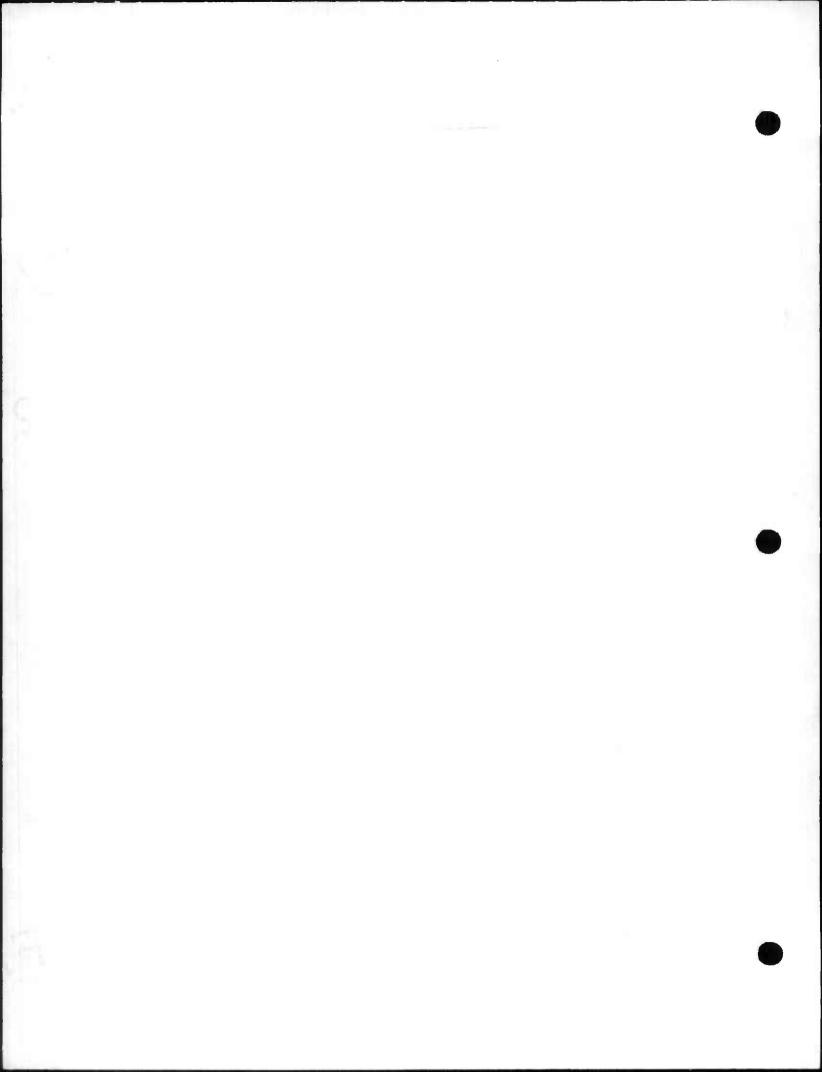
111 PENN STREET, BALTIMORE, MARYLAND 21201

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH :000 <u>James</u> Joseph Rada March 7, 1995 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs last hirthday) 7. DATE OF BIRTH
(Morith, Day, Year)
March 24,1916 IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Fireign DAYS HOURS 1 X M 2 - F 78 YAS. 213-07-4591 Maryland detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Elizabeth's Hall, Apt. M210 BAltimore County Towson RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore County Towson Maryland 1 YES 2X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2300 Dulaney Valley Road 21204 U.S.A. death. Page 6 may be retained by the hospital or attending physician. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puario Rican, atc.) 1 YES 2X NO Specify: BY Specify: 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EOUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) President Food Service 12th Grade 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame Frank Unknown pe notified at Rada Mary Unknown Pfarr **BE** page 5 should 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haryland 19a. INFORMANT'S NAME (Type/Print) 2 124 High Falcon Road, Reisterstown, Rd. 21136 R. Rada James pe 20a. METHOD OF DISPOSITION
1 🖸 Buriat 2 🗆 Cremation 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must funeral director, 4 Donation 5 Other (Specify) Moreland Memorial Park 3 - 10Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 6415 Belair Road Baltimore, Md. -21206 John C. Miller, Inc. athleen filled in by the ours after the medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, ahock, or heart failure. List only one cause on each line Interval Between cremation, or IMMEDIATE CAUSE (Final Onset and Death disease or condition DUE TO (OR AS A CONSEQUENCE OF) attending physician and completely event, resulting in death) Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. signed by the 24a. WAS AN AUTOPS? PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS and AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE Health a 1 TES 2 NO OF DEATH? 1 YES 2 NO peen PHYSICIAN: 23 After this certificate has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item the State EXAMINER? HOSPITAL: OTHER 1 TYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked. with Natural 5 Pending 1 YES 2 NO BY death Investigation 2 Accident 3 Sulcide 28a. PLACE OF INJURY — At home, ferm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: A 4 Homicide item 29a, CERTIFIER TIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) end manner ee stated. FUNERAL I Ξ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 ___ MEDICAL_EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 8 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. George LaRocco, 7505 Osler Drive, Towson, Maryland 21204

P. RECUSTRAN'S SIGNATURE

31. DATE FILED (Month, Day, Year)

wid

31. DATE FILED (Month, Day, Year) WAK 1 3 1995

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Typo, Print)

Fowler

32. REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours are death. Page 6 may be retained by the hospital or attending physician and completely filled in the fluencial director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or minoral.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once.

	blh									93	UI	000
	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	TMEN ICAT	T OF I	HEALTH DEAT	AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH	AV	3.	TIME OF DEATH
	Leonard					Ro	ostek		Mar 11	1995	YEAR	537 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLA	CE (State or Foreign
	218-18-8249	1 XM 2 🗆 F	66	YRS.	MONTHS	DAYS	HOURS	MIN.		928	Country	> -
	9a. FACILITY NAME (If not institution, give str	eet and number)			9b. CIT	Y, TOWN	OR LOCATIO	ON OF DE			TY OF DEATH	1
8	2901 Hudson Str	eet				Bal	ltimo	re			NA	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			I								
R	MD.	21/0				OR LOCA					100	I. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	N/n		DI	44	ME					- 6	YES 2 NO
FUNERAL	20 . 11	0				10	. ZIP CODE		J.	4,171	EN OF WHAT	
N	2901 HUDSON	91.						122			0 /	7.
	1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	YES 2 K			If yes, sp	ecify Cubar	ı, Maxica	HC ORIGIN? (Specify Ye in, Puarlo Rican, etc.)	s or No—	I4. RACE — A Black, WY	American Indian, lite, atc.
В	3 Widowed 4 Divorced	IF YES, GIVE V	AR OR DATES			1 YES	2 NO	Specify	y:		Specify; 1	Tr
G	15. DECEDENT'S EDUC	ATION	16a. DE	CEDENT'S	USUAL C	OCCUPATION	ON	**	16b. KIND OF BU	SINESS/INDI	ILUH!	/=
	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5		ive kind of v Do NOT us	vork done e retired.)	during mo	st of working	9			• • • • • • • • • • • • • • • • • • • •	
P.	8		4	BIN	ET	M	HER	_	WOOT	LUOL	2K	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	ER'S NA	ME (First, Middle, Maiden		-	
BE (JOHN KOST	EK					JE	-SCI	E TERL	Knu	SKI	
10 B	199, INFORMANT'S NAME (Type/Print)	- 11	196	b. MAILINO	ADDRES	S (Street I	and Number	or Rural I	Route Number, City or Tow	n, State, Zip (Code)	
F		STEK	0	2901	HUI	501	0 5	7.	BALTO.	MD	- 217	2224
	20a, METHOD OF DISPOSITION 1 Burlet 2 Cremetton 3 Remo	vel from State	20b. PLACE	AND DATE	F DISPO	SITION	ame of		OATE 20c, LO	CATION - C	ity or Town,	State
	4 ☐ Donation 5 ☐ Other (Specify)		HOL		SAR	YU	EM.	3-1	5-95 BI	410-	Co. 1	4D.
	21. SIGNATURE DE FUNERAL SERVICE LICE FLOWERS	. Ska	ede &		22. S	KAL	DA P	S OF FA	2879 II	O, M	D- Z	1224
	23. PART I. Enter the diseases of co	emplications the	t caused the de	ath. Do n	ot ente	r the mo	de of dyle	ng, aucl	h as cardiac or reap	iratory arre	at,	Approximate
	ahock, or heart failure. L	lat only one cau	ise on each iine	1,								Interval Between Onset and Death
	disease or condition resulting in death)	Ather	oscles	ohz	. (CUTCH	lion	1251	ular o	Lize	40-	
			(OR AS A CONSEC							.00		
Z	Sequentially list conditions.	<u> </u>										
ERTIFICATION	If any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE OF	j):							
2	CAUSE (Disease or Injury											
	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEC	DUENCE OF	7):						1	
CER	d.											
- 11	PART II. Other algnificant conditions	contributing to	death but not n	eauiting I	n the u	nderlyin	g cause g	iven in	Part I. 24s. WAS AN	AUTOPSY	24b. WEF	E AUTOPSY FINOINGS
3									PERFOR		CON	LABLE PRIOR TO IPLETION OF CAUSE
밀									1 YES 2	PANO		DEATH?
-	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	SП	NO F	UNC	PTAIN	J PT		1	YES 2 NO
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL			E OF OEAT			01101	IX D XIII	1 4			
Sic		HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHE!	R:	s X Bas	Idence	8 Other (Specify)			
ξ	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIME	E OF	28c. INJ	URY AT		28d. DESCRIBE HOW I	NJURY OCCU	JREO	
ВУ Р	1 Netural 5 Pending	(Month, D	ay, 19ar)	INJ	URY M		RK? (ES 2 🗌	NO				
	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE O	F INJURY — At hor	me, <i>t</i> erm, a	treet, lac	tory, offic	•		281. LOCATION (Street	and Number or	r Rural Route	Number,
回	4 Homicide determined	building,	atc. (Specify)						City or Town, State)			
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	AN: To the heat of	my knowledge de-	ath occur-	d at at a	time det	and at-	and d	to the cause(a) and mer			
₩.	(Check only one) 2 MEDICAL EXAMINER	: On the beals of a	camination and/or i	nvestication	n. In my 4	oninion 4	and place,	d at the	to the cause(a) and mer	mer ea atated	J,	
	29b. SIGNATURE AND TITLE OF CERTIFIER	10/	/		,	- primert, Q						
H	AND SIGNATURE AND TULL OF CENTIFIER	411	1				29c. LICE				SIGNEO (Mon	
0	20 NAME AND ADDRESS OF REPON WILL	1/2	5				C	.C.I	M.E .	M	ar 11	1995

Penn Street, Baltimore Maryland 21201

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

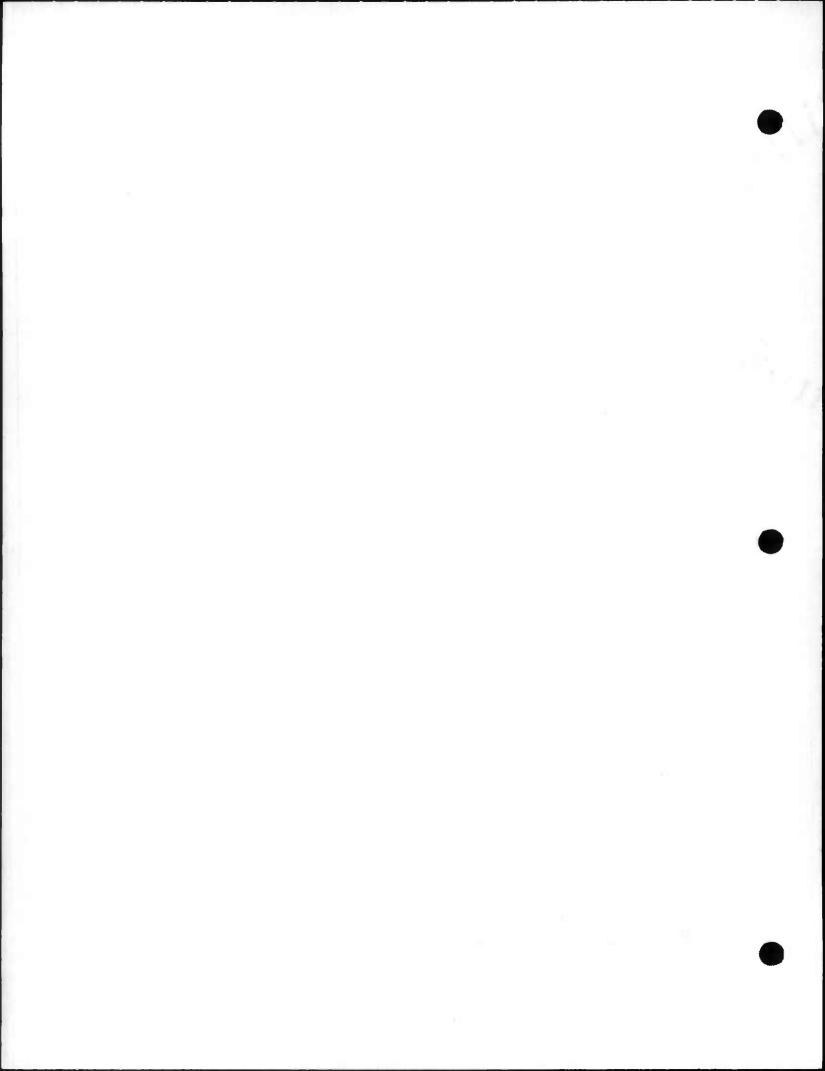
FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

	1. DECEDENT'S NAME (First,	Middle Lesti			OLITTI	IOAII		DLA		HEG. NO).		
	DOREATHA		LAVERNE		RANDOI	חם				2. DATE OF DEATH MONTH	MY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMB		5. SEX		s. lest birthday)		R 1 YEAR	IE LIMDEI	1 24 HRS.	7. DATE OF BIRTH	10	95	2327 M
	220-71-993	1	1 🗆 M 2 💢 F	35	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)		Country)
	9a. FACILITY NAME (If not in	stitution, give st	treet and number)			9b. CIT	r. TOWN	OR LOCATI	ON OF DE	Aug. 18		19 Ma	
E C	1427 W F	avotto	Stroot										2011
5	1427 W. F					Be	птп	nore				N/A	
DIRECTOR	10a. STATE	10b. COUNTY				Y, TOWN							10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER		N/A		Ва	1tir							YES 2 NO
RA	709 N. Ca	1 houn	Ctroot	-			101	f. ZIP COD			10g. CIT		HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	Illouil	12. WAS DECEDEN					212				USA	
	1 Never Married 2	Married	FORCES? 1	YES Z	NO		If yes, sp	ecify Cubi	in, Mexica	IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)	e or No-	Black,	- American Indian, White, etc.
B	3 Widowed 4 Divo	rced	IF YES, GIVE V	WAR OR DATES			1 🗌 YES	2 XNO	Specify	r:		Specify	Black
COMPLETED	15. DECI (Specify only	EDENT'S EDUC	CATION	16a	DECEDENT'S	USUAL O	CCUPATIO	ON		16b. KIND OF BU	SINESS/INI	DUSTRY	
	Elementery/Secondary (0		College (1-4 or 5	+)	(Give kind of life. Do NOT u.			IST OF WORK	ng				
MP	12 Years				Home	nake	er			Own	nome		
	17. FATHER'S NAME (First, Mi William R		Pandol	nh (Sr			18. MOT	HER'S NA	ME (First, Middle, Meider Mercer	Surname)		
띪	19a. INFORMANT'S NAME (7)		Kalluo]	rbu, r									
임	Elaine Ju				700	ADDRES	S (Street a	and Number	or Rural F	Route Number, City or Tov	n, State, Zh	Code)	21217 Maryland
	20s. METHOD OF DISPOSITI			000 000					201	eet bal	CIMO	re,	Maryland
	1X Burial 2 Cremation 4 Donation 5 Other	n 3 🗆 Ramo	oval from State	cemetery M +	CE AND DATE (ther place)	m o t	meof	3	3/105/95_0	CATION —	City or Tow	m, Stata Maryland
	21. SIGNATURE OF FUNERAL		ENSEE	- I MC.	. 210	7		O ADDRE	SS OF FAC	Det 1904			
	1 Perce	1 de	4.50							5240			stown Roa
	9	7"	arrow			Ch	atm	lan-	Harı	is F/H	Balt	imor	e, Md2121
	23. PART I. Enter the di- ahock, or he	eart fallure. L	omplications the let only one ceu	t ceused the ise on eech	line.	not enter	the mo	de of dy	ing, suci	n aa cerdlec or reap	iratory an	reat,	Approximate Interval Between
	iMMEDIATE CAUSE (Fin- disease or condition	el	P	200	_	_							Onset and Death
	resulting in death)	→ ,		YYY	C. C. S.	2	The	2	WE				
_		_	000	OH AS A CON	SECUENCE OF	7):	10	1 _0	700				
ğ	Sequentially list condition if any, leading to immediate		DUE TO	(OR AS A CON	SEQUENCE OF	F):		no	131				
CAT	cause. Enter UNDERLY!	NG											į
CERTIFICATION	CAUSE (Disease or Injur that initiated events	· 1	DUE TO	(OR AS A CON	SEQUENCE OF	F):							E
E	resulting in death) LAST		l										
1 11	PART ii. Other algnificer	nt conditions	contributing to	death but n	ot resulting	n the un	deriving	Ceuse (alven in i	Part i. 24s. WAS AN	ALCTORROY	045.7	WERE AUTOPSY FINDINGS
EDICAL									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PERFO	RMED?	- 1	AWAILABLE PRIOR TO COMPLETION OF CAUSE
										YES 2	□ NO		DF DEATH?
2	DID TOBACCO US	SE CONTR	IBLITE TO CA	LISE OF D	EATH VE	s П і	VO F	LING	EDTAIN				YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO		TO CA		LACE OF OEAT			7 0140	LKIAII	101			
Sic	EXAMINER?		HOSPITAL:	ER/Outpetien	1 3 DOA	OTHER 4 Nur	ing Hom	e 5 □ Re	sidence	6 Ty Other (Specify) at			
美	27. MANNER OF DEATH		28a. DATE OF (Month, D	INJURY	28b. TIM	E OF	28c, INJ	URY AT		28d. DESCRIBE HOW			
ВУ		ending restigation	(Money, De	ey, rear)	INJ	URY M		RK? (ES 2	NO				
	3 Suicide 6 C	Could not be	28e. PLACE O	F INJURY A	t home, farm, s	treet, fact	ory, office		\neg	281. LOCATION (Street City or Town, State)		or Rural Ro	ute Number,
ETE	4 Homicide d	etermined		,						Ony or lown, State,			
<u>P</u>	29a. CERTIFIER (Check only	FYING PHYSIC	IAN: To the best of	my knowledge	, desth occurre	d at the t	lme, dste	and place,	and dua	to the cause(a) and me	ner as stat	ed.	
COMPL										lime, data and place, ar			end manner as stated.
Ш О	_ A	OF CENTIFIER							NSE NUM				Month, Day, Year)
00	//\V	1	100				ļ		C.M.1		.	_	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (ITEM 27) (Type,	Print)		<u>U.</u> (0 1111		141	ar ()	7 1995
	m	M)IX	NO	1	11 Pen	n St	reet	. Ra	ltim	ore Mæyla	and 2	1201	
- 11			1 44					, ,,,,,,,		THEY LIVE ATO	une 2	LCUL	
	MAR 1 0 100E	11.	12. DEGISTRA	S SIGNATUR	E								
	MAR 1 3 1995	Jelia	A Walter	S SIGNATUR	E								

DIVISION OF VITAL RECORDS, P.O. BOX 68760



FOR STATE REGISTRAR	STATE OF	MARYLAND / DEPAR Certif	TMENT OF H	EALTH AND I		YGIENE EG. NO.
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATN
	Mable	Jeanette	Spark	S	March	10,
4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs, last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	BTN

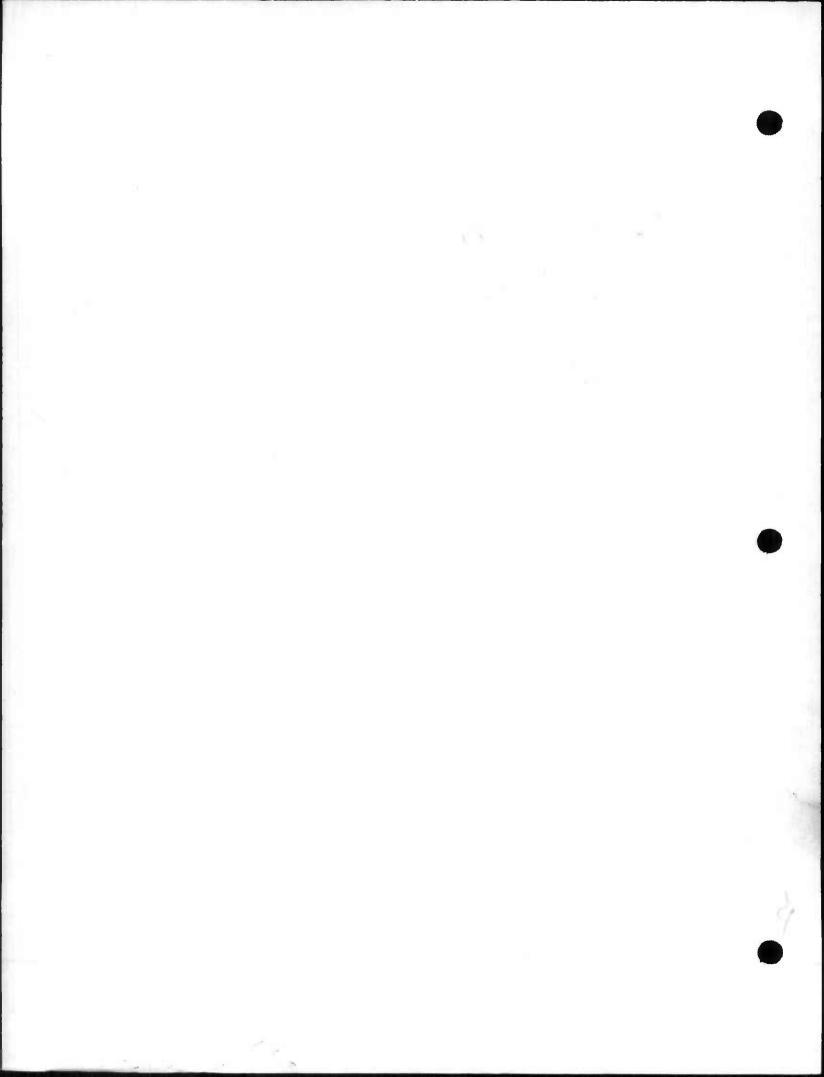
	2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH
	Mable Jeanette Sparks March 10, 1995 12:18 Pm
	SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) #FUNDER 1 YEAR #FUNDER 24 HRS. 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign Country) Country)
	216-01-3435 1 M 2 XF 89 YRS. MONTHS DAYS HOURS MIN. NOV 22, 1905 Maryland
	a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN
8	717 Maiden Choice Lane, St.C #305 Catonsville Baltimore
DIRECTOR	RESIDENCE OF DECEDENT
2	10d. INSIDE CITY
0	Maryland Baltimore Catonsville 1 VES 2X NO
¥.	De. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?
FUNERAL	717 Maiden Choice Lane, St.C # 305 21228 USA
ᆵ	I. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ANO 13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerlo Rican, etc.) 14. RACE — American Indian, Black, Whita, etc.
BY	Widowed A □ Diversed IF YES, GIVE WAR OR DATES 1 □ YES 2 🔀 NO Specify: Specify:
	White
	(Specify only highest grade completed) (Give kind of work done during most of working the Dr. NOTT
7	Conege (1-4 or 5+)
COMPLETED	12 Corporate Secretary Plumbing Supply Co. PATHER'S NAME (First, Middle, Maiden Surparse) 18. MOTHER'S NAME (First, Middle, Maiden Surparse)
	John Thomas Bean Minnie Louisa Bush
BE	De. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2	Roberts R. Sparks 717 Maiden Choice Ln., StC 305 Balto., MD 21228
1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	20b. PLACE AND DATE OF DISPOSITION OATE Commenter of Commentary of other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 5 Other (Specify) Densition 6 Other (Specify) Den
	. SIGNATURE OF FUNDERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
	Cremation Society of Md., Inc.
	George E. MacNabb 299 Frederick Road Balto., MD 21228
	3. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, abock, or heart fellure. List only one cause on each line. Approximate interval Batween
	WMEDIATE CAUSE (Final Onset and Beath
	esuiting in death)
Ì	DUE TO (OR AS A CONSEQUENCE OF):
CERTIFICATION	equentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):
E	any, leading to immediate
윤	AUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):
E	esulting in death) LAST
	0
MEDICAL	ART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO
8	1 U YES 2 NO COMPLETION OF CAUSE OF DEATH?
¥	1 YES 2 NO
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
5	WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:
PHYSICIAN	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 M Residence 6 Other (Specify)
E	MANNER OF DEATH 288. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY AT WORK? 286. DESCRIBE HOW INJURY OCCURED
BY	1 Netural 5 Pending M 1 YES 2 NO
	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)
	4 Homicide determined
P.	e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
	b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
H H	(View Klade)
2	NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
	Charles R. Graham, Jr., M.D. 299 Frederick Road Balto., MD 21228
	DATMAR MIN. 301995 July Division Rangel
	THE TO LIGHT WINDOW THE COLUMN TH

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 hours after death with the State Dept. of Health and Mental Hygines port to burial, correction, or removal.

MIMPORTANT: If then 28 is marked or them 28 shows any inliny or other trainmails event leaven leave must be applied as pages.

	FOR STATE REGISTRAR	STATE OF MARYLAND / DEP/ CERTI	ARTMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
	1. OECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH
	FERDINAND	SYSKO		FEBRUARY 27, 1	995 18:01 M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest birthda	MONTHS DAVE MOURS MIN	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)
	90. FACILITY NAME (If not institution, give str	1X M 2 D F 74 YRS		APR-29,1920	NAZAKETH, PA.
E .	JOHNS HOPKINS H	·	BALTIMORE CITY	EATH 9c. COU	INTY OF PEATH
5	RESIDENCE OF DECEDENT				NA
DIRECTOR	70		CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	HAMPTON	101. ZIP CODE	10g. CIT	1 X YES 2 NO
FUNERAL	398 N. BROAT	> ST. EXT.	1806	4	U.S.A.
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO	13. WAS DECENDENT OF HISPA It yes, specify Cuban, Mexic	NIC ORIGIN? (Specify Yea or No-	14. RACE — American Indian, Black, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 TES 2 NO Speci	dy:	Specify: TF
0	15. DECEDENT'S EDUCA (Specify only highest grade of		I'S USUAL OCCUPATION of work done during most of working	18b. KINO OF BUSINESS/INI	DUSTRY
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+) life. Do NOT	use retired.)	RESTAUR	A157
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	OWER	- OPERATOR	AME (First, Middle, Maiden Surname)	7-7
BEC	FRANK	Sysko	AN	NA MAUREK	
TO BE COM	19a. INFORMANT'S NAME (Type/Print)	19b. MAILE	NG ADDRESS (Street and Number or Rural	Route Number, City or Town, State, Zij	p Code)
	JENUIE A. S.	15KD 378	N. BROAD ST.	EXT. NAZAR	ETH, PA 18064
100	1 Burial 2 Cremation 3 Removed A Donation 5 Other (Specify)	val from State 20b. PLACE AND DAT	TEOF DISPOSITION (Name of prother place) (NEW ETGEN)	DATE 20c. LOCATION -	City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE OCE	HSEE / / A	22. NAME AND ADDRESS OF FA	ACILITY RATTO	MD-21224
CYCLE	Thomas .	Apade h	SKARDA FI	4. 2829 H	חמנו כדי
	23. PART I. Enter the diseases, or co	omplications that caused the death. Di	not enter the mode of dying, suc	ch as cardiac or respiratory ar	
	IMMEDIATE CAUSE (Final				interval Between Onset and Death
	disease or condition reaulting in death)	DUE TO (OR AS A CONSEQUENCE			48 hours
		DOE TO (OR AS A CONSCIDENCE	(OF):		
O L	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE	OF):		
<u> </u>	CAUSE (Disesse or Injury	DUE TO JOB AS A COMPROMENO	-00		
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE	OF):		
	PART II Other significant conditions	contributing to death but not resulting	-6-0		
OICAL	PART II. Other argumeant conditions	contributing to death but not reaultin	g in the underlying cause given in	PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
ED				1 U YES 2 NO	OF DEATH?
N. A	DID TOBACCO USE	CONTRIBUTE TO CAUSE	OF DEATH YES N	O M	1
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HØSPITAL:	26. PLACE OF DEATH (C/	neck only one)	
14S	1 YES 2 NO	1 Inpatient 2 ER/Outpatient 3 DOA 26s. DATE OF INJURY 26b. 1	4 Nursing Home 5 Residence IME OF 28c. INJURY AT	6 ☐ Other (Specify) 28d. DEŞCRIBE HOW INJURY OC	William .
BY PI	1 Natural 5 Pending		M 1 YES 2 NO	280. DESCRIBE NOW INJURY OC	CONED
	3 Suicide 6 Could not be	28e. PLACE OF INJURY — At home, farm building, etc. (Specify)	n, atreet, lactory, office	281. LOCATION (Street and Number City or Town, State)	r or Rural Route Number,
ETE	4 Homicide detarmined				
COMPLETED		IAN: To the best of my knowledge, death occu			
00		: On the basis of examination and/or investiga			
BE	29b, SIGNATURE AND TITLE OF CERTIFIER	R.J. FINE	1 M.O. 29c. LICENSE NU	MBER 29d. DAT	TE SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITEM 27) (Ty	rpe, Print)	1001	-12/173
	R.I. FINNEY	JOHN) HOPKIN	VS HOSPIDAL	BARRIAE, MA	ANYLAND
	31. DATE FILED (Month, Day, Year) WAR 1 3 1995	32. REGISTRAR'S SMNATURE		/	



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATN 3. TIME OF DEATH March last hirthday IF UNDER 1 YEAR 169 1 - M 2 PF DAYS HOURS MIN. YRS permit. Pages 1, 2, 3 should CITY, TOWN OR LOCATION OF DEATH DEATH DIRECTOR More STATE Y, TOWN, OR LOCATION 10d. INSIDE CITY 1 TES 2 NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2 0 this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS MAS DECEDENT EVER IN U.S. ABINED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Curtan, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: RACE — American Indian, Black, White, atc. ORCES? 1 YES 2
YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced OIC COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY of work done use retired.) condary (0-12) re (1-4 or 5 +) notified at once. TAFATHER'S NAME (First, Middle, Last 16. MOTHER'S NAME (First, Middl BE AME (Type/Print) MAILING ADDRESS (Street 2 3 be METHOD OF DISPOSITION ACE AND DATE OF DISPOSITION DATE must 2 Cremation 3 R 6 - Other (Specify) medical examiner RE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS OF osep 22 esses, or complicatione that caused the deeth. Do not enter the mode of dying, auch ae cardiec or reepiratory arrest, Enter the Approximate shock, or art failure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** or other traumatic event, the disease or condition_ FAILURE KENAL resulting in death) DUE TO (OR AS A CONSEQUENCE OF) INFARCTION CUTE MY D CARDIAL
DUE TO (OR AS A CONSEQUENCE OF): ACUTE CERTIFICATION Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING HEART ONGESTIVE CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evente resulting in deeth) LAST Injury, PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO DIABETE item 23 shows any DEPENDENT COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 5 Masidence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural Pending Investigation 1 YES DIRECTOR: After the hours after death w 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 99 3 Sulcida 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homtelde item 28 1 SERTIFYING PNYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the beals of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. SIGNATURE AND TITLE OF CERTIFIER 8 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 0 my Mun leve 13/95 2 WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) MARGO MENGNOEZ M.D 7505 OSVER DV MD TOW SON 21204 31. DATE FILED (Month, Day, 16.)
MAR 1 3 1995

ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/24/95 t.t L.R.B. ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/24 Item # 9c,18 Film # g 721 3-13-95 N.A. Per funeral home

95 07564

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_							REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lex	10				2. DATE MONT	OF DEATH	AY	3.	TIME OF DEATH
	KATELYN				GT		02	1995	YEAR	3:07A
	216-43-2703	1 🗆 M 2 💢 F	i. AGE (In yes. last birthday) YRS.	FUNDER I YEA	S HOURS MIN.		оғантн п. Day. War)	20223	MARY	ACE (State or Form
CTOR	HARBOR HOSPIT RESIDENCE OF DECEDENT				IMORE CI	EATH		SE COUNT	Y OF DEAT	
DIRECTOR		ARUNDEL		TY, TOWN OR LO						M. INSIDE CITY LIMITS?
FUNERAL	100 S. Midfield	d Road			21090			U.S.		T COUNTRY?
B	11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT & FORCES? 1 : IF YES, GIVE WAR	YES 2 XNO	If yes,	RECENDENT OF HISPAN apacify Cuben, Maxica ES 2 X NO Specifi	in, Puerto	H? (Specify Yes Ricen, etc.)	ar No 1		American Indian. Mille, etc. WHITE
COMPLETED	15. DECEDENT'S EE (Specify only highest pre Elementary/Secondary (0-12) N/A	DUCATION ide completed) Cuttege (1-4 or 5+) N/A	16a. DECEDENT: (Give Aind of the Do NOT)	B UBUAL OCCUPY work done during use retired.)	KTION most of working		KIND OF BUI	SINESS/INDUS	ETRY	
BE CO	17. FATHER'S NAME (FIRST, MICHING, LIBIT) JAMES K. VOGT				BEVERL	ΥΥ	ANN	1	SCH	neider INIEDER
٥	GLORIA VOGT				of and Number or Aural					
"	20a, METHOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITION		DAT	THE REAL PROPERTY.	CATION - CH	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN	
	1 X Burtal 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Spacify)	moval from State	MEADOWRI	DGE CEM	FTFRY	1	A 10/2000			aryland
	21. SIGNATURE OF FUNDINAL SERVICE	ubentar /	1	22. NAME	AND ADDRESS OF FA	CILITY				ar y rand
	1 6 6 -1	Niche II	N. F. J.	1 6	TALL TRICC	400 4 4 4 4 100	PLAT THE	MIE D.	Α	
	23. PART I. Enter the diseases, o	SUDDEN 11	seemed the death. Do	not enter the r	STALLINGS R111 Mount mode of dying, suc	ain	Doad D	acador	a Mr	Approximat Interval Bet
TIFICATION	23. PART I. Enter the diseases, o shock, or heart failure immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. SUDDEN 11 BUE TO (OF	neach line.	NOROME YNDROME	R111 Mount	ain	Doad D	acador	a Mr	Approximat Interval Bet
AL CERTIFICATION	23. PART I. Enter the diseases, o shock, or heart failure immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. SUDDEN II BUE TO (OF DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. D. DUE TO (OF d. D. DUE TO (OF d. D. D. DUE TO (OF d. D. D. D. D. D. D. D. D. D. D. D. D. D.	R AS A CONSEQUENCE O	YNDROME. YNDROME. YNDROME.	R111 Mount mode of dying, suc	ain h as carr	Road P diac or reupi	Pasader Iratory arres	a, MD	Approximation of the control of the
MEDICAL	23. PART I. Enter the diseases, o shock, or heart failure immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions.	a. SUDDEN 11 B. DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF DUE TO (OF	PAS A CONSEQUENCE OF AS A	NOROME. YNOROME. YNOROME.	R111 Mount node of dying, such node of dying, such node of dying, such node of dying, such node of dying, such	ain h as card	Road P	Autoresy	24h WE	Approximation of the second of
MEDICAL	23. PART I. Enter the disease, o shock, or heart failure in the shock, or heart failure in th	a. SUDDEN 11 B. DUE TO (OF the country of the coun	PAS A CONSEQUENCE OF AS A	In the underly ES NO OTHER:	ing cause given in	Part I.	Poad P diac or reupi	Autoresy	24h WE	Approximate Interval Bet Onset and 6 Onset
MEDICAL	23. PART I. Enter the diseases, o shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock	a. SUDDEN 11 B. DUE TO (OF the country of the coun	PLACE OF DEATH Y 26. PLACE OF DEATH 26. PLACE OF DEATH 26. PLACE OF DEATH 26. PLACE OF DEATH 26. PLACE OF DEATH 26. TIME	In the underly ES NO OTHER: 4 ON Name of 28c. 1	ing cause given in UNCERTAIN HOUSE Hesidence	Part I.	Poad P diac or reupi	Autorsy arres	24h WE	Approximation of the second of
PHYSICIAN: MEDICAL	23. PART I. Enter the diseases, o shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock in the	a. SUDDEN 11 a. SUDDEN 11 bue to (or b. Due to (or c. Due to (or d. d. TRIBUTE TO CAUS HOSPITAL: 1 impatient 20 EI (Month, Day,	THE PROPERTY OF THE PROPERTY O	In the underly ES NO OTHER: 4 ON Nursing 14 EE OF 256. JURY M 1	Ing cause given in UNCERTAIN UNCERTAIN IN THE STATE OF THE SINGLE OF THE STATE OF THE SINGLE OF T	Part I.	24e. WAS AN PERFOR	Autorsy arres	24h WE	Approximation of the second of
BY PHYSICIAN: MEDICAL	23. PART I. Enter the diseases, o shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock	B. SUDDEN 1: B. SUDDEN 1: DUE TO (OF DUE T	PAS A CONSEQUENCE OF AS A	In the underly ES NO OTHER: 4 ON Nursing 14 EE OF 256. JURY M 1	Ing cause given in UNCERTAIN UNCERTAIN IN THE STATE OF THE SINGLE OF THE STATE OF THE SINGLE OF T	Part I.	24e. WAS AN PERFOR	AUTOPSY INCOME.	24h WE CO	Approximation of the control of the
BY PHYSICIAN: MEDICAL	23. PART I. Enter the diseases, o shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock of the shock	B. SUDDEN 1: B. SUDDEN 1: DUE TO (OF DU	TABLE OF DEATH YORK OF DEATH Y	In the underly In the underly	ing cause given in UNCERTAIN UNCERTAIN UNCERTAIN IN 19 Plesidence NJURY AT UNCERTAIN UNCERTAIN IN 19 Plesidence NJURY AT UNCERTAIN U	Part I. 6 □ Other 28d. DET	24a. WAS AN PERFOR 1997 ES 2	AUTOPSY INED? In NO NUMBER OF COUNTY OCCUR	24h. WE ARED	Approximate Interval Bets Onset and Conset a
E COMPLETED BY PHYSICIAN: MEDICAL	23. PART I. Enter the diseases, o shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock, or heart failure in the shock of the shock	A. SUDDEN II B. BUDGEN II BUE TO (OF C. DUE TO (OF B. DUE TO (OF C. DUE TO (OF B. DUE TO (OF C. DUE TO (OF B. DUE TO (OF C. DUE TO (OF B. DUE TO (OF C. DUE TO (OF B. DUE TO (OF C. DUE TO (OF B.	TABLE OF DEATH YORK OF DEATH Y	In the underly In the underly	ing cause given in UNCERTAIN UNCERTAIN UNCERTAIN IN 19 Plesidence NJURY AT UNCERTAIN UNCERTAIN IN 19 Plesidence NJURY AT UNCERTAIN U	Part L. Part L. S Other 286. Det	24a. WAS AN PERFOR 1997 ES 2	AUTOPSY INCOME. AUTOPSY INCOME. IN O NUMBER OF THE OCCUPANT OCCU	24h. WE AND OF 17	Approximate Interval Bet Onset and 6 Onset
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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BALTIMORE, MARYLAND 21215-0020

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

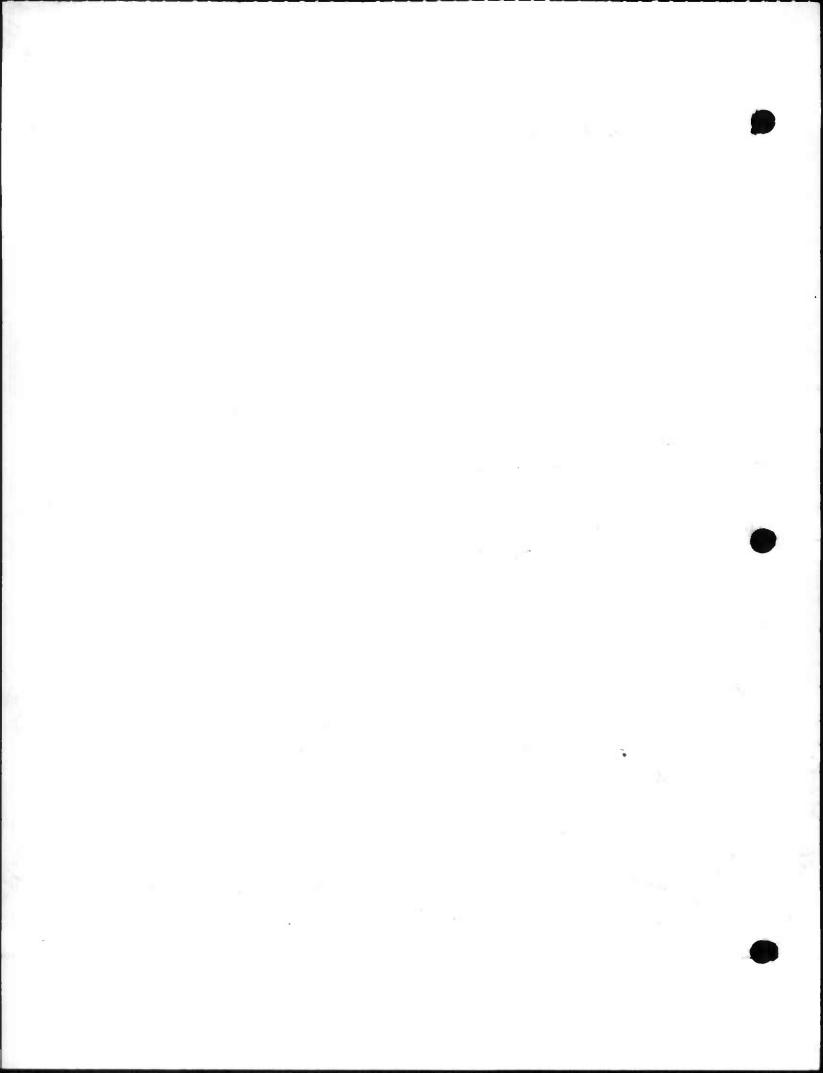
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - REGISTRAR CERTIFIC	CATE OF DEATH	REG. NO).								
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF OEATH		3. TIME OF DEATH							
	Fauth M. Wilson		March	11 95	3:00 AM							
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.1	BIRTHPLACE (State or Foreign							
	213-78-2588 10 M 2 DE 37 YRS. "	ONTHS DAYS HOURS MIN.	Aug 5	962	Country) H &							
	9a. FACILITY NAME (If not institution, give street and number)	b. CITY, TOWN OR LOCATION OF D		9c. COUNTY	OF DEATH							
OR	Sinai Hospital Balto MA											
DIRECTOR	10a. STATE 10b. COUNTY (10c.,CITY, TOWN OR LOCATION 10d. INSIDE CITY											
E.	106_CITY, TOWN OR LOCATION 106_CITY, TOWN OR LOCATION 104_INSIDE CITY 2 MITS? 12 Yes 2											
	10e. STREET AND NUMBER 10g. CITIZEN OF V											
RA	4030 Edgewood Food 21215 UST											
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE —											
	1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If yes, specify Cuban, Mexico	an, Puarto Rican, atc.)		14. RACE — American Indian, Black, White, atc.							
В	3 Wildowed 4 Divorced		Specify: Black									
ED	15. OECEDENT'S EDUCATION 16a. OECEDENT'S U: (Specify only highest grade completed) (Give kind of wo	SUAL OCCUPATION k done during most of working	16b. KIND OF BU	SINESS/INOUST	RY							
E	Elementary/Secondary (0-12) College (1-4 or 5 +)	retired.)										
MP	12th NA Uni	Lnown	unk	nown								
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NA	ME (First, Middle, Maider	Sumame)								
BE	William D. Wilson Se,	E++10	= L. D(とろろ								
2	19a. INFORMANT'S NAME (Type/Print)	DDRESS (Street and Number or Rural	11 0	vn, State, Zip Coo	(a)							
	William 4. Wilson Jr. 14030	Edgewood	X Kd. Do	140. W	(d. 21215							
	20a_METHOO OF DISPOSITION 1 ABurlai 2 Cremation 3 Ramoval from Stata 20b.PLACE AND DATE OF	DISPOSITION (Number of		CATION - City	or Town, State							
4 Donation 5 Other (Specify) Deer of Kidge Centery 3 16 9 Balto.												
	T. SUNDE BUENSE	22. MAME AND ADDRESS OF F		LIFOT								
	Jumis P. Scott		ALVEOMET		4D 21215							
	23. PART . Enter the disease, or complications that coused the deeth. Do no shock, or heart fellure. List only one cause on each line.	enter the mode of dying, aud	h as cardiec or resp	iretory errest,								
ı	IMMEDIATE CAUSE (Finel				Interval Between Onset and Death							
	e. Aquired Immunodeficiency Syndrome											
	OUE TO (OR AS A CONSEQUENCE OF):											
8	Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF)											
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING											
윤	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
E	resulting in death) LAST				į							
S	0,											
DICAL	PART II. Other aignificent conditions contributing to death but not resulting in	the underlying ceuse given in	Part I. 24e. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO							
8			1 _ YES	777	COMPLETION OF CAUSE OF DEATH?							
ME				7	1 YES 2 NO							
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES	□ NO 🗖 UNCERTAIN	N 🗆									
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? LOSPITAL: 26. PLACE OF DEATH	(Check only one)										
YSI	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4	□ Nursing Home 5 □ Residence	6 Other (Specify)									
	27. MANNER OF DEATH 1 Netural 5 Pending 28a. OATE OF INJURY (Month, Day, Year) 1 Netural 5 Pending	Y WORK?	28d. OESCRIBE HOW	INJURY OCCURE	ED							
ΒY	2 Accident Investigation	M 1 YES 2 NO										
8	3 Suicide 8 Could not be 4 Homicide determined	et, factory, office	281. LOCATION (Street City or Town, State	end Number or R)	ural Route Number,							
COMPLETED	On OFFICE											
AP.	29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred one)											
Š	one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation,	nd due to the ce	use(a) and manner as stated.									
BE (29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year)										
2	J. M. Intern	AS24023	21 DM9842	Man	h 11, 1995							
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P.	rint)										
- 11		N 11.										
	David Michalson Sing; Hospital 31. Part Eller MAR 1 31 1995 Juli Dawalor Karlell	Baltimore										



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

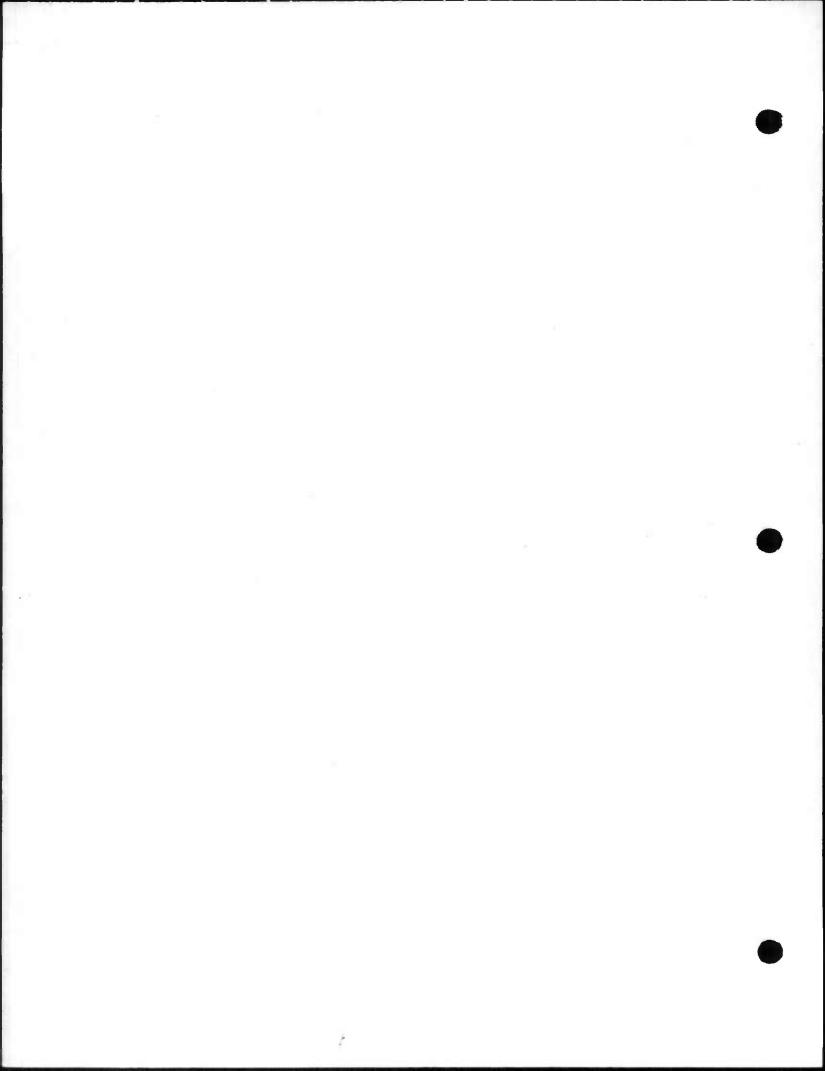
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

4	1	-		AT	E STR	AR		
,	1.	D	ECE	DE	e'Ti	NA	ME	(Fi
					Pro-			_

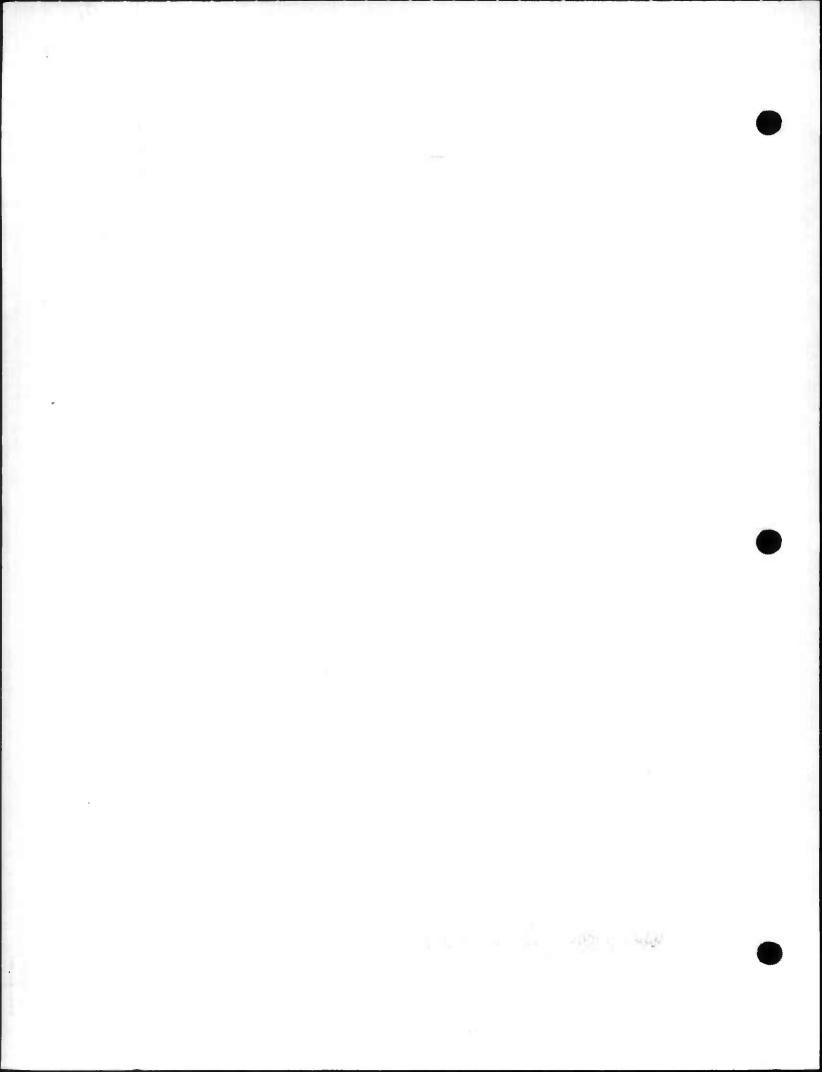
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR				CERTIFIC	ATE	OF DEATH		REG. NO				
1. DECEDENT'S NAME (First,	Middle, Last)						2. DAT	E OF DEATN		WE4.5	3. TIME OF DEATH	
THEODO		R.		WHITA	KER			RCH 9.	1995	YEAR	2:39A	М
4. SOCIAL SECURITY NUMB	100		6. AGE (In yrs		F UNDER 1 Y		2 047	05.00000	- / / -		HPLACE (State or Foreign	1
242-54-4649		1 X X M 2 □ F	60	YRS.	ONTHS D	AYS HOURS MIN.	FEE	B. 22, 1	1935		CAROLINA	
9e. FACILITY NAME (If not in:	stitution, give stre	et and number)		9	b. CITY, TO	WN OR LOCATION OF D	EATN		9c. COU	NTY OF I	DEATN	
THE JOHN	S HOPKI	NS HOSPI	TAL		BAL	TIMORE CIT	Y			n/	a	
10a. STATE	10b. COUNTY			10c. CITY, 1	OWN OR I	OCATION			_		10d. INSIDE CITY	=
MARYLAND		n/a			BALT	IMORE					LIMITS?	
10e. STREET AND NUMBER					07121	101. ZIP CODE			10a. CIT	IZEN OF	WHAT COUNTRY?	\dashv
1542 BR	OADWAY					21213	3		UNI.		STATES	
11. MARITAL STATUS		12. WAS DECEDENT FORCES? 1 [13. WAS	DECENDENT OF NISPA	NIC ORIGI	IN? (Specify Yes	or No-	14. RAC	E — American Indian,	\dashv
1 Never Married 2 3 Widowed 4 X Divor		IF YES, GIVE WA				e, specify Cuban, Maxic YES 2 NO Speci		Rican, etc.)		Spec	ek, White, etc.	
15. DECI (Specify only	EDENT'S EDUCA	(TION completed)	18a.	DECEDENT'S US	r done durin	PATION ng most of working	16	b. KIND OF BUS	SINESS/IND	DUSTRY		\neg
Elementary/Secondary (0-		College (1-4 or 5+)		Me. Do NOT use n	etired.)	ig most or working						
7 TH	11	-		LABORE	R			CONST	RUCT:	ION		
17. FATHER'S NAME (First, Mi		AVED.				18. MOTNER'S N			,			
JESSIE	WHITA	ANER				BERT		EDMON		_		
ROSA	SMITH		ĺ			reet and Number or Rural					21 202	
20a, METNOD OF DISPOSITI	OTTZ TTT		20h BI A	CEANDDATEOF			7	BALTIM	CATION -	77.00	21202	
1 X Burlai 2 Cremation 4 Donation 5 Donation		al from Stata		crematory or other	plece)	ETERY	DA'				,	
21. SIGNATURE OF FUNERAL		NSEE	1111.	Z10N	7	E I E IN T		14] L	ANSU	JMINE	, MARYLAND	-
Jereso	100	0.0			LINA	. C. MARCH		1101				- 1
iMMEDIATE CAUSE (Findisesse or condition resulting in death) Sequentielly list condition if any, leading to immediate. Enter UNDERLY in that initiated events resulting in deeth) LAST	Sequentlelly list conditione, If say, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Diseas											
PART II. Other significer	nt conditions	contributing to d	eeth but no	ot resulting in t	he under	iying ceuse given in	Part I.	24a. WAS AN PERFOR		24b	. WERE AUTOPSY FINDING	GS
								1 TYES 2			COMPLETION DF CAUSE OF DEATH?	3
							_	ĺ ·			1 YES 2 NO	- 1
DID TOBACCO US		BUTE TO CAU	ISE OF DI	EATH YES	☐ NC	UNCERTAI	NE					
25. WAS CASE REFERRED TO EXAMINER?		OSPITAL:	26. Pt	LACE OF DEATH (Check only	one)						
1 TYES 2 NO		Supportient 2 🗆		3 🗆 DOA 4	☐ Nursing	Home 5 - Residence	6 🗆 Oth	er (Specify)				
	Pending	28a. DATE OF III (Month, Day		28b. TIME O	F 280	WORK?	28d. DE	SCRIBE HOW II	JURY OC	CURED		
3 Suicida 6 C	nvestigation Could not be	28s. PLACE OF building, et	homa, farm, stree	et, factory,		281. LOC	CATION (Street a	nd Number	or Rural I	Route Number,	-	
4 Homicide d	letarmined						J.,					
						data and place, and due					n) and manner as stated.	
29b. SIGNATURE AND TITLE	OF CERTIFIER	MI				29c. LICENSE NUI	MBER 4	0	29d. DATI	E SIGNED	(Month, Dey, Year)	7
30. NAME AND ADDRESS OF	PERSON WHO	LETED CAUSE	OF DEATH (TEM III (Tipoe, Prin	W)	O. His	Vel V	344	7.1	DA	<	7
31. DATE FILED (Month, Day, Y	/ 1	32 REGISTRAR	Rende	1	V-0 0	- 1100	7		-	20.		\dashv
MAR 1 3 19	95 Jul	the angressian	- Purchas	v .								





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH YEAR THELMA WOODS MARCH 995 11:54 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 1 | M 2 | X DAYS 27 67 YRS. 220-22-2485 MARYLAND JUN.6, 1927 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 1006 SHELBANKS ROAD APT BALTIMORE CITY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND Baltimore n/a 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1006 SHELBANKS ROAD APT. b1 21225 UNITED STATES 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 TES 2 NO 84 Specify: 3 Widowed 4 Divorced Specify: **BLACK** COMPLETED 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) LABORER n/an/a 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE GEORGE COUPLING **FLIZABETH** 196. MAILING ADORESS (Street and Number or Rural Route Number, City or Rown, State, Zip Code)
OWINGS MILLS
10626 PARK HEIGHTS AVENUE BALTIMORE, M 19a. INFORMANT'S NAME (Type/Print) 2 BEVERI Y BOOKER 21117 MD pe 20b. PLACE AND DATE OF DISPOSITION / Name of OATE 20c. LOCATION - City or Town, State must CEMETERY LANSDOWNE MARYI AND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND AGORESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert fallure. Liet only one ceuse on each line Interval Between IMMEDIATE CAUSE (Final Onset and Daath disease or condition ş auhethmia Cardiae decond resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): oughtive Heart
DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate Outer DUE TO (OP AS A CONSEQUENCE OP cause. Enter UNDERLYING ray CAUSE (Disease or Injury thet initiated events Bronchial resulting in death) LAST 6 O reary PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY anterioscherotic Cardio Vascular Hyperterrion shows any Discare 1 TES 2 NO Speendont OF DEATH? Insulin Diabetes 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN PHYSICIAN: 3 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b, TIME OF INJURY 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, tactory, offica building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28 18 ETED 8 Could not be 4 Homicide determined 29s. CERTIFIER
ICheck only
CERTIFYING PHYSICIAN: To the best of my knowledge, dash occurred at the time, data and placa, and due to the cause(a) and menner as stated. COMPL 2 ___ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Therepour 228 1395 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suew. Thompson
31. DATE FILED (Morth, Day, York
MAR 0 9 1995 Poteert. M Md 2127 32. REGISTRAR'S SIGNATURE



Pages 1, 2, 3 should

permit.

funeral director, page 5 should be detached for use as the burial-transit notified Pe must examiner in by the fi removal. medicai n and completely filled in by to burial, cremation, or remo the the death certificate be executed with traumatic attending physician ntal Hygiene prior to other 9 signed by the atte amy Shows Deen . DR ATTENDING PHYSICIAN: The law of DIRECTOR: After this certificate has be hours after death with the State Dept. 6 marked, 28 hours a Hem TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II HOSPITAL

29b. SIGNATURE AND

BE

2

95 07569 ITEM: 1. PER F.H. FILM G-721 3/14/95 t.t. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) ROY ARMSTRONG 2. DATE OF DEATH 3. TIME OF DEATH ,1995 Roy March 4:30 P 6 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 4 M 2 - F YRS. 249- 68- 7217 1/28/42 S.C 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MD. GENERAL HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. BALTIMORE THE YES 2 INO 10e, STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 1347 MARTIN DRIVE 21229 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 JUNO IF YES, GIVE WAR OR DATES! 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, alc. 1 🗐 Never Married 2 🔲 Married 1 TES 2 I NO BY 3 Widowed 4 Divorced Specify: Specify: AFR. AMERICAN COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 8+) 12 tolic DEPUTY SHERIFF 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) damon ARMSTRONG BE JOHNNIE ESTELLE ARMSTRONG 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HELEN WILLIAMS 1347 MARTIN DR. BALTIMORE, MD. 20e, METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of 4 Donation 6 Other (Specify) SACRED HEART OF JESUS 3/10/95 DUNDALK. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO, MD. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Approximata** Interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition Cancer Of Esophagus unknown reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): 100 CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2X NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 X Inpetient 2 ER/Outpetient 3 DOA 1 TES 2 NO ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending M 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, Ierm, streat, factory, offica building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 🛣 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or in vestigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

01108

Sivan Sivanamakrishnan, M.D. c/o Maryland General Hospital

WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE



29d. DATE SIGNED (Month, Day, Year)

▶ 3-6-95

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
1. DECEOENT'S NAME (First	Middle, Last)	ALTOFF	SARA B	. ALTHO	FF			2. DATE OF DEATH 3. TIME OF DEATH MAR. 8,1995 YEAR 11:25 A			
4. SOCIAL SECURITY NUME 214-20-0623			E (In yrs. las	t birthday) II	UNDER 1 YE		UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) SEPT.11,1	IPLACE (State or Foreign y) ARYLAND		
98. FACILITY NAME (If not in 6 BYWAY RD.		reet and number)			OWING		OCATION OF DE		9c. COU	TY OF D	EATH
RESIDENCE OF DEC	10b. COUNTY										
MARYLAND	BALTIN	MORE		BAL!	FIMOR	Œ					10d. INSIDE CITY LIMITS? 1 YES 2 XNO
7608 LORRY LANE 100. STREET AND NUMBER 21208 100. CITIZEN OF WHAT COUNTRY'S USA										VHAT COUNTRY?	
11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	8 2 Dy	MED 10	If yes	s, specify	DENT OF HISPAN y Cuban, Maxica X NO Specify	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)		— American Indian, d, white, stc.	
(Specify only	EDENT'S EDUC y highest grade o	completed)	/G	CEDENT'S US ive kind of work Do NOT use n	done durin	PATION og most of	working	16b. KIND OF BUS	SINESS/IND	USTRY	
Elementary/Secondary (0	l-12)	College (1-4 or 5+)		URSE	инес.)			HEALTH	CAR	Ξ	
17. FATHER'S NAME (First, M	iddle, Last)					18	MOTHER'S NA	ME (First, Middle, Maiden	Surname)		
BENJAMIN		BREYER			_		ANNA				ROSENTHAL
19a. INFORMANT'S NAME (7		Route Number, City or Town	n, State, Zip	Code)							
MRS. ANITA CARSTENS 6 BYWAY RD. OWINGS MILLS, MD 21117											
20a, METHOD OF DISPOSITION Surfal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215											
23. ART I. Enter the diveases, of complications that caused the death. Do not antar the mode of dying, such as cardiac or reapiratory arrest, about, or heart failure. List only one cause on each line. Approximate interval Between											
iMMEDIATE CAUSE (Firdisease or condition resulting in death)	Comment	. Ou o			-Qu	ce	~				interval Between Onset and Dasth
		OUE TO (OR AS									
Sequentially list conditi if any, leading to imme- cause. Entar UNDERLY!	diata	OUE TO (OR AS	A CONSE	DUENCE OF):							
CAUSE (Disease or injuthst initiated events resulting in death) LAS		DUE TO (OR AS A CONSEQUENCE OF):									
PART ii. Othar significa	nt conditions	contribution to death	but not s	amitina la f	ha undad	lulan e-	was shire le l	Part i. 24a, WAS AN			
			DGC HOCK		- discari	lyllig ca	iusa given in	PERFOR	MED?	246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
DID TORACCO II	SE CONTR	IBUTE TO CAUSE	OF DEA	TH VEC			UNCERTAIN				1 YES 2 NO
25. WAS CASE REFERRED TO		IBOTE TO CAUSE		E OF DEATH			UNCERIAIN	<u> </u>			
EXAMINER?		HOSPITAL: 1 Inpatient 2 ER/O	ipatient 3		THER:	Home 5	Rasidence	6 Other (Specify)			
27. MANNER OF DEATH		28a. OATE OF INJUR' (Month, Day, Year		28b. TIME O	F 28c	INJURY WORK?	AT	28d. OEŞCRIBE HOW II	NJURY OCC	UREO	
1 Natural 5 Pending (MORA), Day, Idal) M 1 YES 2 NO											
	Could not be determined	28s. PLACE OF INJUI building, atc. (S)	RY — At ho	me, farm, atre	it, factory,	offica		281. LOCATION (Street a City or Town, State)	nd Number	or Rural R	loute Number,
29a. CERTIFIER 1 CERT	IFYING PHYSIC	IAN: To the best of my known	wledga, de	ath occurred a	t the time.	data and	place, and due	to the cause(a) and man	Der aa state	ed.	
		: On the basis of axaminat									and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
Ole	1 1	1 VADR	V	M			DH	1614			ch 8,1995
30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUSE OF I	EATH (ITE	1 27) (Type, Pri	nt)						

Old Cout Rd.

*** THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-fours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

31. DATE FILED (Month, Day, Year)
MAR 1 4 1995

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

32. REGISTRAR'S SIGNATURE

8

DHMH-16 Rev 1/89

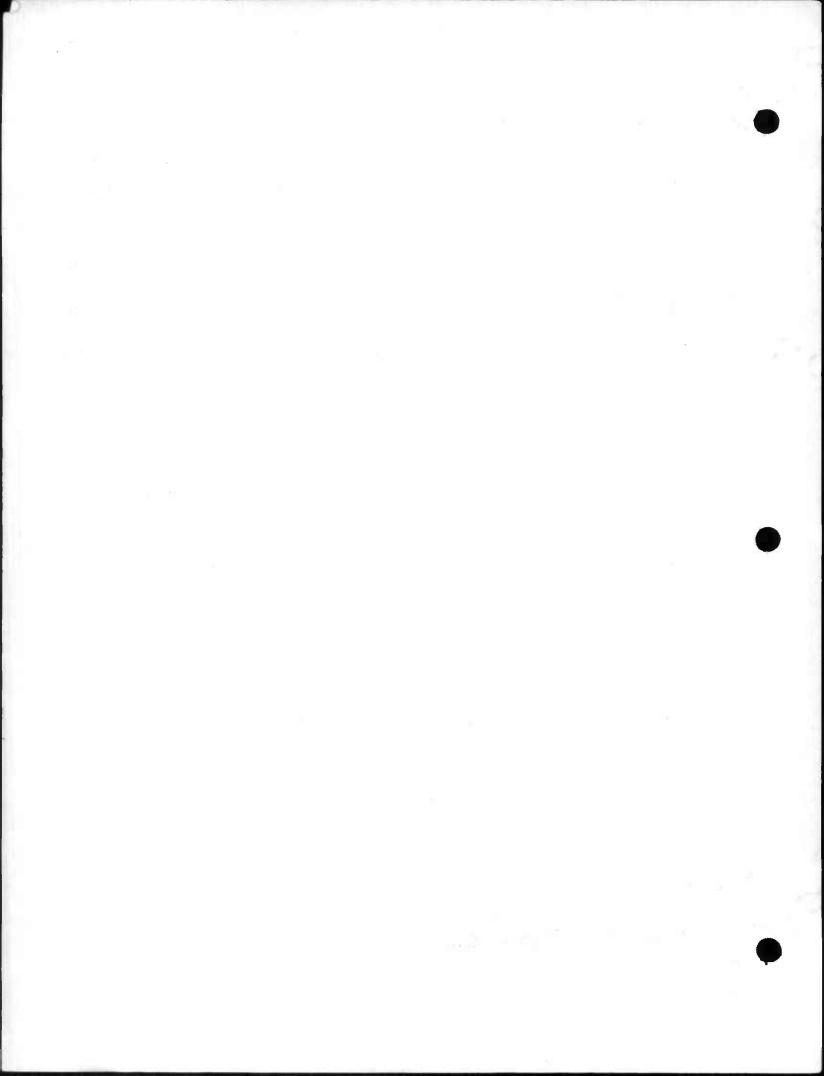
Battlinere Uns 21208

ASTA PAR

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

			1. DECEDENT'S NAME (First,		drews.	gn.						2. DATE O MONTH Marc	, D	AY 1995	YEAR	3. TIME OF DEATH
			4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. In	ast birthday)	IF UNDER		IF UNDER		7 0475 0	C DIOTAL		S BIRTHE	PLACE (State or Foreign
	pin		218-09-09		1 X 2 M 2	78	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)			nyland
	2, 3 should	S.	90. FACILITY NAME (If not institution, give street and number) 22 Strawberry Court Baltimore 9c. COUNTY OF DEATH Baltimore													
	-	RECTOR	RESIDENCE OF DEC	10b. COUNTY	Y		10c. CIT	Y, TOWN O	R LOCAT	TION					_	10d. INSIDE CITY
	ift. Pag	<u>a</u>	Md.				Be	iltin	non	e						LIMITS?
	it perm	RAL	100. STREET AND NUMBER	an + lo	nd Ava				101	1. ZIP CODE 2/2				10g. CITIZ		S.A.
0	physician. burial-transit permit. Pages	FUNER	11. MARITAL STATUS		12. WAS DECEDEN			13. W	AS DEC	CENDENT O	F HISPAN	NIC ORIGIN?	(Specify Yes	or No—	14. RACE	- American Indian.
5-0020	attending physician. se as the burial-trar	BY	1 Never Married 2 3 X-Widowed 4 Divo		IF YES, GIVE W		INO			2 X NO		in, Puarto Ri y:	can, etc.)		Specify	White, atc.
	or atter	COMPLETED	(Specify only	highest grade	completed)		ECEDENT'S Give kind of b. Do NOT u	work done di	CUPATIO	ON ost of workin	g	16b. i	KIND OF BU	SINESS/INDL	JSTRY	
10 2	the hospital or detached for u	MPLE	Elementary/Secondary (0	-12)	College (1-4 or 5	") Ma	chir	rist					Crow	n co	nk c	& Seal
LAN	by the hospital or att be detached for use at once.	_	17. FATHER'S NAME (First, M. Charles H.		BOWA A					_		ME (First, Mi			, .	
ARY	5 should t	3BE	190. INFORMANT'S NAME (7)	rpe/Print)	news, s	<i>κ</i> .	9b. MAILING	ADDRESS	(Street a	and Number	or Rural I	LNE Route Numbe	r, City or Tow	ambe n. State, Zip	RTL Code)	
-		5			Andnews			_		_	Ct.					
IOR	6 ma ctor, p		20e. METHOD OF DISPOSITI t XBurlai 2 Cremetic 4 Donation 8 Other	n 3 🗆 Rem	oval from State		enatory or of	ther place)		ame of		3/7		Lto.	,	,
TIN	death. Pag tuneral dir l. examiner		21. SIGNATURE OF FUNERAL	•				22. N	AME A	ND ADDRES		CILITY				
BAI	0 = 0		4		Miller			75	27	Hun	for	dRd	. Ba	ral.	, Md.	21234
	filled in b ion, or rer		iMMEDIATE CAUSE (Findisease or condition_	aart fallura.	List only one cau	sa on aach lin	a.								eat,	Approximate interval Between Onset and Death
68760.	completely ial, cremati event, t		disease or condition resulting in death) a. Phi sheral Vascular Disease How How the Due to (or as a consequence of):													
X 68	e be execute sician and confort to burist traumatic	LION	Sequentially list conditi		b. DUE TO	(OR AS A CONSI	EOUENCE O	F):								
BO	physicia physicia ne prior	FICA	cause, Entar UNDERLYI CAUSE (Disease or inju	NG	c	(OR AS A CONSI	OUENCE O	FI:								
P.O.	ath certificat tending phy al Hygiene p or other	ERTIFICATION	that initiated events resulting in death) LAS	· [d	(on no n consi	OULIVOE O	.,.								
DS,	the dea y the atl id Ments injury,	AL C	PART II. Other significa	nt condition	s contributing to	death but not	rasulting	in the und	lariyin	g causa g	jivan in	Part i.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS
COR	signed by Health art	EDICAL	Anterioscle	jotic	Cardis	ascul	an d	rise	as	ll,		_	1 YES 2	1/		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
R	sho seen	Σ	DID TOBACCO		CONTRIBUTE	TO CAU	SE OF	DEAT	H Y	'ES 🗆	NO	_	•			1 TES 2 NO
VITAL	in: The law ficate has t State Dept item 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:			OTHER	28. PL			eck only one)				
FV	the the	PHYS	1 YES 2 NO		1 Inpatient 2 I		3 🗆 DOA	4 - Nursi	ng Hom	URY AT	sidence	8 Other		NJURY OCCI	IBED	
N OF	After this death with	ВУ Р		Pending nvestigation	(Month, D	ay, Year)	IN.	M	WO	YES 2	NO					
DIVISION	CTOR: A after d 28 is	8		Could not be detarmined	28e. PLACE O building,	F INJURY — At h etc. (Specify)	ome, ferm,	street, fecto	ry, offic	•		281, LOCAT City or	TION (Street of Town, State)	end Number o	or Rural Ro	ute Number,
5	Per Per Per Per Per Per Per Per Per Per	COMPLET			CIAN: To the best of											
	TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: 11		29b. SIGNATURE AND TITLE			Camination and/or	Investigatio	en, in my op	inion, d	29c. LICE			nd place, an			and manner ee stated. Mopth, Day, Year)
	THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DE FILED THE DEFE TH	TO BE	Ma	me	M.D	•				13	50	82		•	3/6	195
	341		Shawti Ran	PERSON WH	-2322	OD PE	EM 27) (Type	St.	-	Bal	1:	MAPA	nu	21	22	4
	7.		MAR 1 4 1995	(d)	32. REGISTRA	R'S SIGNATURE	, v- <u>U</u>			quet 17 6	<u> </u>		,100	. 61	0101	1
			- 1000	0	- Amenday	material										



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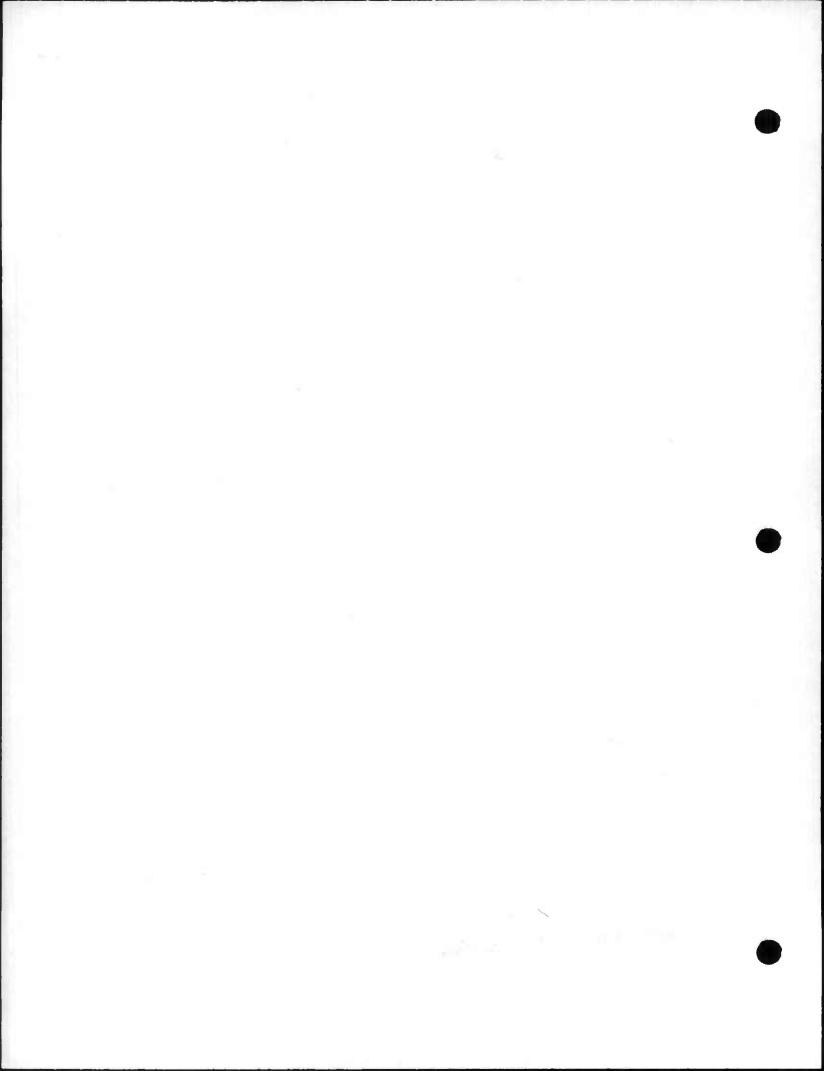
TO THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY			HEALTH AND	MENT	AL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last) PAUL	W.	BA	3	2. DAT MON	TE OF DEATH		5 ^{YEAR}	3. TIME OF DEATH 6:10 am			
	213-72-7336	TO THE OF BIRTH							6. BIRTHPLACE (State or Foreign Country) MARYLAND			
TOR	99. FACILITY NAME (If not institution, give stree Saint Joseph Media				OR LOCATION OF OWSON, ME	DEATH		9c. COUNTY OF DEATH Baltimore				
DIRECTOR	10e. STATE 10b. COUNTY	IMORE	10c. CIT	PARKV						10d, INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	1712 FORREST AN	VE.			21234				ZEN OF W	HAT COUNTRY?		
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	It yes,	ECENDENT OF HISP specify Cuben, Mexi ES 2 NO Spec	can, Puerto	ilN? (Specify Yea o Ricen, atc.)		14. RACE Black,	- American Indien, White, etc.		
LETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	College (1-4 or 5+)	life. Do NOT u	work done during se retired.)			Sb. KIND OF BUS		USTRY			
COMPL	17. FATHER'S NAME (First, Middle, Last)		SUPER	VISOR	18. MOTHER'S N		SWEETH		T CU	JP		
l w l	WILLIAM J. BARF	RANGER					H QUAI			7		
TO B	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 EAST JOPPA RD. TOWSON, MD. 212									86.		
	20e. METNOD OF DISPOSITION X Suriel 2 Cremetion 3 Removal from State Donation 6 Other (Specify) PARKWOOD CEMETERY OTHER DISPOSITION (Name of PARKWOOD CEMETERY PARKWOOD CEMETERY OTHER DISPOSITION (Name of PARKWOOD CEMETERY OTHER DISPOSITION											
	21. SIGNATURE OF FUNERAL SERVICE LICEN	love		490	AND ADDRESS OF R RY W. J 5 YORK	RD.	BALTO).,MI	D. 2	1212.		
	23. PART I. Enter the diseases, or com- ahock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	npilcationa that couse it only one couse on A.I.D.S.	ed the deeth. Do a	not enter the n	node of dyling, au	ch aa ca	rdiec or reapi	ratory arr	eat,	Approximata interval Between Onset and Deeth		
NO NO	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST											
빙	d											
PHYSICIAN: MEDICAL	SEVERE ANEMIA									WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?		
2	DID TOBACCO USE CONTRIB		OF DEATH YE	S 🗆 NO I	UNCERTA	IN 🗆				1 - YES 2 - 40		
GA	25. WAS CASE REFERRED TO MEDICAL	IOŠBÍTAL:	26. PLACE OF DEA	TN (Check only on								
IXSI	1 YES 2 NO 1	☐ iripatient 2 ☐ ER/Out			me 5 🗆 Residence	6 □ Oth	er (Specify)					
ву Рн	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1	IJURY AT YORK? YES 2 NO	20d. DE	EŞCRIBE HOW IN	IJURY OCC	CURED			
	3 Suicide e Could not be determined 26e. PLACE OF INJURY — At home, ferm, street, tactory, office building, stc. (Specify) 26e. PLACE OF INJURY — At home, ferm, street, tactory, office building, stc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									ute Number,		
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: 0	N: To the best of my known on the basis of examination								end menner es stated.		
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Kom	m	3	29c. LICENSE NU D 37			29d. DATE		SIGNED (Month, Day, Year) - 12 - 55		
	30. NAME AND ADDRESS OF PERSON WHO C				IARYLAND	21204	Ų.					
	BOON P. LIM M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204 WAR 1 4 1995											

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

		REGISTRAR		C	ERTIF	ICATE	OF	DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)							2. DATE	OF DEATH	NY .		. TIME OF DEATH
		ANNA JOSEPHIN							MONTI 3	- 1	1 –9	5	10:33 "
		4. SOCIAL SECURITY NUMBER	5. SEX 6. /	AGE (In yrs. Ia.		IF UNDER	1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTN , Day, Year)		6. BIRTNPL Country)	ACE (State or Foreign
Pin		217-12-9410	87	YRS.					-19-1	907	MARY	/LAND	
3 should	oc	9a. FACILITY NAME (If not institution, give st		20100	_			OR LOCATION OF D	EATN			TY OF DEA	
رة د	DIRECTOR	PIKESVILLE N. & CONV. CENTER PIKESVILLE BALTIMO										DRE	
Jes 1	<u> </u>	10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											Od. INSIDE CITY
- P	PIG	MARYLAND BALTIMORE											LIMITS?
permit. Pages 1,	AL	10e. STREET AND NUMBER					101	1. ZIP CODE			10g. CITI		AT COUNTRY?
Sit	FUNERAL	7 SUDBROOK LAN	E					21208			U.	S.A.	
physician. burial-transit	S.	11. MARITAL STATUS	12. WAS DECEDENT EV FORCES? 1	ER IN U.S. AF	RMED	13. \	MAS DEC	CENDENT OF HISPA	NIC ORIGIN	? (Specify Yes	or No	14. RACE -	- American Indian,
	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	NO			ecify Cuban, Maxico 2 NO Specia		tican, etc.)		Specify:	Whife, atc.
or attending r use as the	ED B												WHITE
or att	ETE	15. DECEDENT'S EDUC (Specify only highest grade	completed)	10	ECEDENT'S live kind of w Do NOT us	work done o	CUPATION Including Including	ON ost of working	16b.	KIND OF BUS	INESS/IND	USTRY	
pital ed fo	7	Elementary/Secondary (0-12)	College (1-4 or 5+)		LERK					SOCIA	T. SE	CIIDT	·π·v
the hospital or attend detached for use as once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		1	DBICIO			16 MOTHED'S NA				CORT	. 1 1
3 E &													
should by 5 should be notified at	BE	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	and Number or Rural					
De reta Ge 5 si e noti	유	FRANCIS T. BURG	СН					ON RD.					21093.
nay be page		20a. METHOD OF DISPOSITION		20b. PLACE	AND DATE O	F DISPOS	TION (Na	ame of	OATI	-		City or Town	
leath. Page 6 ma funeral director, p xaminer must		Burial 2 Cremation 3 Ramo	rval from State	NEW	CATH	EDR.	AL	CEM.	3/9	5 BA	LTO.	,MD.	
death. Pag funeral dii examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22.1	NAME A	ND ADORESS OF FA					
		1 \1.00 m	Mais	111				Y W. JI					
n by the removal.		23. PART I. Enter the diseases, or c	omplications that car	used the de	eath. Do n	ot anter	the mo	YORK I	CD.	BALTO	· ML	21	212,
hours after of in by the or remove		snock, or neart fellure. I	let only one cause of	on each line	ð.			or dying, soc	ii aa cara	ac or reapi	atory arri	,	Interval Between
B On #		iMMEDIATE CAUSE (Fine) disease or condition	LUNG	CA	NICE	2							Onset and Death
completely file ial, cremation event, the		resulting in death)	OUE TO (OR										6 months
executed with and complete to burial, crem matic event	z												İ
e be execut sician and c rior to buris traumatic	CERTIFICATION	Sequentielly liet conditions, If any, leading to Immediate DUE TO (OR AS A CONSEQUENCE OF):											
ate b hysici prio	<u>5</u>	CAUSE (Disease or Injury											
ing plane	빌	that initieted events reaulting in death) LAST	DUE TO (OR	AS A CONSE	OUENCE OF) :							
tal H)	55	d											
the d the d		PART II. Other aignificant conditions	contributing to dear	th but not r	reaulting is	n the un	deriying	g ceuse given in	Part I.	24a, WAS AN		24b, W	ERE AUTOPSY FINDINGS
that ed by h and	EDICAL	1) Alzheimors De	ementia						PERFORMED? AVAILABLE PRI				MILABLE PRIOR TO OMPLETION OF CAUSE
sign Sign Healt									_	1 TYES 2	□ NO		F DEATN?
been of of	Z. M	DID TOBACCO USE CONTR	IBUTE TO CAUSE	E OF DEA	TH YE	SIIN	10 [UNCERTAIL	N FI			1 .	YES 2 NO
The lase to De	IAI	25. WAS CASE REFERRED TO MEDICAL. EXAMINER?			E OF DEAT								
AN: tificat e Sta	SIC	1 YES 2 PNO	HOSPITAL:	Outpatient 3	□ DOA	OTHER		e 5 🗆 Residence	6 🗆 Other	(Specify)			
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to IMPORTANT: It item 28 is marked, or Item 23 shows any Injury, or other traus	PHYSICIAN:	27. MANNER OF DEATN	28a. DATE OF INJU (Month, Day, Ye		28b. TIME	OF	28c. INJ		_	CRIBE HOW IN	JURY OCC	URED	
ig Pt ter th ath w	ВУ	1 Natural 5 Pending 2 Accident Investigation				M		YES 2 NO					
R: Af		3 Suicide 8 Could not be	28s. PLACE OF INJ building, etc. (URY — At ho Specify)	me, ferm, e	treet, facto	ry, office		28f. LOCA	TION (Street a	nd Number	or Rural Roul	te Number,
RECTO RECTO Ins aff	ETE.	4 Nomicide datarmined											
AL OF	길		IAN: To the best of my k										
SPITE INERA Thin 7	COMPL	2 MEDICAL EXAMINER	: On the beals of examin	ation and/or i	Investigation	n, In my of	ilnion, d	eath occured at the	time, data	end place, and	dua fo the	cause(a) ar	nd manner as stated.
HE HE HE ORTA	ш	296. SIGNATURE AND TITLE OF CERTIFIER)	00				29c. LICENSE NUI]			onth, Day, Year)
5 5 5 € F € F € F € F € F € F € F € F €	TO B	Melilie &	cerce	MU				0-	459	31	▶ 3	-13-	85
	-	30. NAME AND ADDRESS OF PERSON WHO		interest in the									
			D 0.7220		K HE	IGH	rs .	AVE. BA	LTO	,MD.	212	15.	
	4	MAR 1 4 1995	32. REGISTRAR'S S	SIGNATURE									
	7	1395 3g	MAR 1 4 1995 Jaka Studente 1										

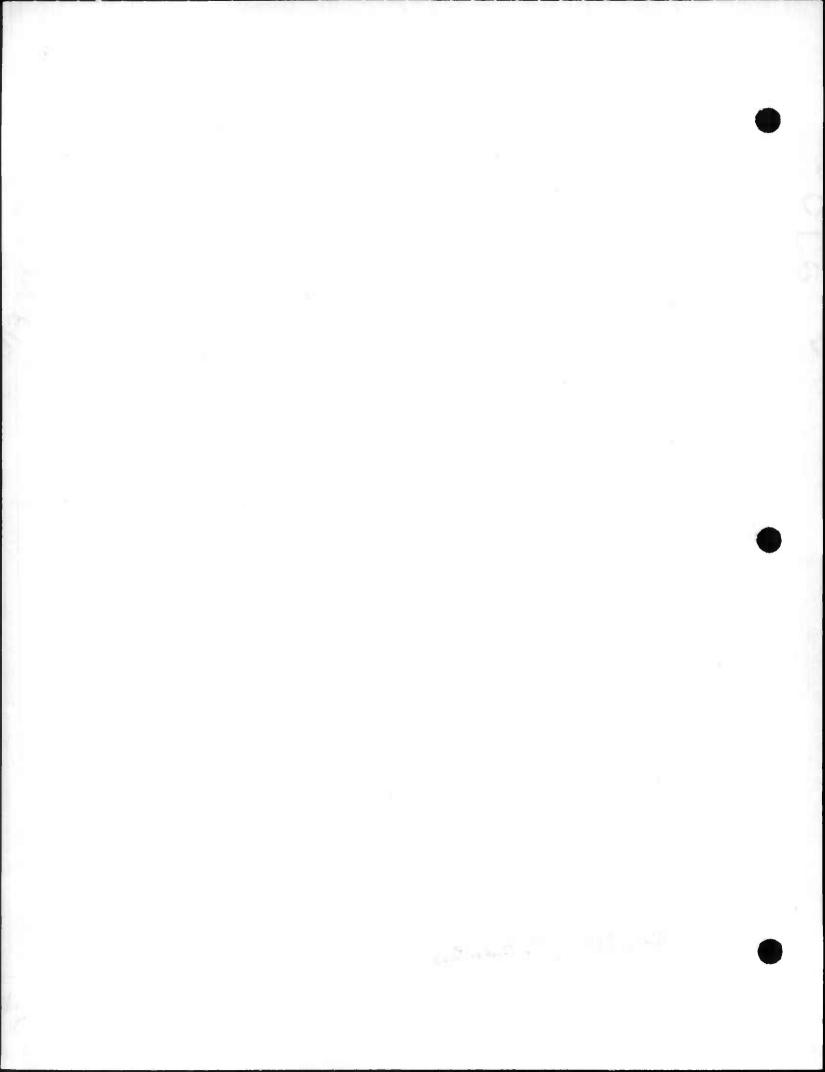


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L OR	TO THE FUNEAR, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	item
PITAL	ERAL	In 72	11:11
HO	FUN	I WITH	HTAN
E O	O THE	e filec	IMPORTANT: It item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be r
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL	HYGIEN REG. NO	E			
	1. DECEDENT'S NAME (First, Middle, Last) NINA BROOKS					2. DATE OF MONTH	F DEATN D	199	YEAR	TIME OF CEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF				CE (State or Foreign	м
	216-18-7274 9e. FACILITY NAME (If not institution, give str		88 YRS.	MONTHS DAYS	HOURS MIN.	4-3	-190	6 1	Country) MARYI	LAND	
DIRECTOR	608 RIDGE RD. FINKSBURG CARROLI									N	
EG	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCA	TION				100	I. INSIDE CITY	
	MARYLAND CARR	OLL		FINKSE	URG	URG					
FUNERAL				10	M. ZIP CODE					COUNTRY?	
N.	608 RIDGE RD.	12. WAS DECEDENT EVER IN	IIIS ADMED	12 488 05	21048 CENDENT OF NISPA				S.A.		
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, a	pecify Cuben, Mexic S 2 NO Speci	an, Puerto Ric		or No —	Black, WI	American Indian, hite, etc.	
E	15, DECEDENT'S EDUCA (Specify only highest grade c	ATION	16a, DECEDENT'S	USUAL OCCUPAT	ON	16b. K	IND OF BUS	I SINESS/INDU		*****	
COMPLETED	Elementary/Secondary (0-12)	work done during m se retired.)	ost of working								
MPI	11		HOUSEW	IFE			HOM	EMAKE	ΞR		
8	17. FATHER'S NAME (First, Middle, Last)	D. T. T. D. 11 C. D. 11			18. MOTHER'S NA			Sumame)			
BE	OTTO NICHOLAS	DIERKSEN			OLGA						
5	190. INFORMANT'S NAME (Type/Print) MARY B. BONARR	IGO			ond Number or Rurel 01 608					JRG, MD.	
	20e. METNOD OF DISPOSITION 1 Buriet 2 Cremation 3 Remon 4 Donation 5 Other (Specify)		PLACE AND DATE etery, cremetory or o EW CATH		ame of	3/9/9		CATION — CI			
	21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAME A	ND AODRESS OF FA	CILITY					
	> William ?	Paresti	_		RY W. J						
	23. PART I. Enter the disesses, or co	mplications that caused	tha death. Do	not antar tha m	YORK ode of dying, suc	RD B	C or reap	matory arres	2.1 et.	212 Approximata	
	shock, or haart failure. Li iMMEDIATE CAUSE (Final disease or condition	ist only one cause on as	ach lina.							Interval Batwe Onset and Dec	ath
	resulting in death)		ric		er					Zyear	\$
2	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):							
<u>8</u>	CAUSE (Disease or injury										
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):							
調用	d.										
AL.	PART ii. Other significant conditions	contributing to death be	ut not resulting	in tha undarlylr	g cause given in	Part I, 24	la. WAS AN			RE AUTOPSY FINOING	GS
8						_ 1	PERFOR		CON	ILABLE PRIOR TO APLETION OF CAUSE DEATH?	4
M										YES 2 NO	
ÿ	DID TOBACCO USE CONTRI				UNCERTAI	N 🗆					
PHYSICIAN: MEDIC		HOSPITAL:	28. PLACE OF DEAT	OTHER:	-						\Box
1YS	1 VES 2 NO	1 ☐ Inpatient 2 ☐ ER/Outpu 28a, DATE OF INJURY	7	4 Nursing Hor	ne 5 Residence						
BY PI	1 Naturat 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIM	URY W	PURY AT DRK? YES 2 NO	28d. DEŞCR	HBE NOW IN	IJURY OCCU	RED		
ETED I	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, ferm, (street, factory, offic	0	28f. LOCATI City or	ON (Street a Town, State)	nd Number or	Rural Route	Number,	
E I	29e. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowl	dge, death occurr	ed at the time, date	and place, and due	to the cause	(e) and man	nor on stated			\dashv
COMPL					e time, data and place, end due to the cause(a) and menner as stated. y opinion, death occured at the time, date end place, and due to the cause(a) and menner a					menner as stated.	
H	296. SIGNATURE AND PITLE OF CERTIFIER	Lus			29c. LICENSE NUI	MBER 050		29d. DATE S	SIGNED (Mor	19. Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO								/ -/	, ,	\dashv
		IS M.D. 33		CALVERT	STREET	r BAL	то.,	MD.			
	MAR 1 4 1995	32. REGISTRAR'S SIGNA	TURE								
		THE PERSON NAMED IN	16.15							DHMH-16 Rev	1/89



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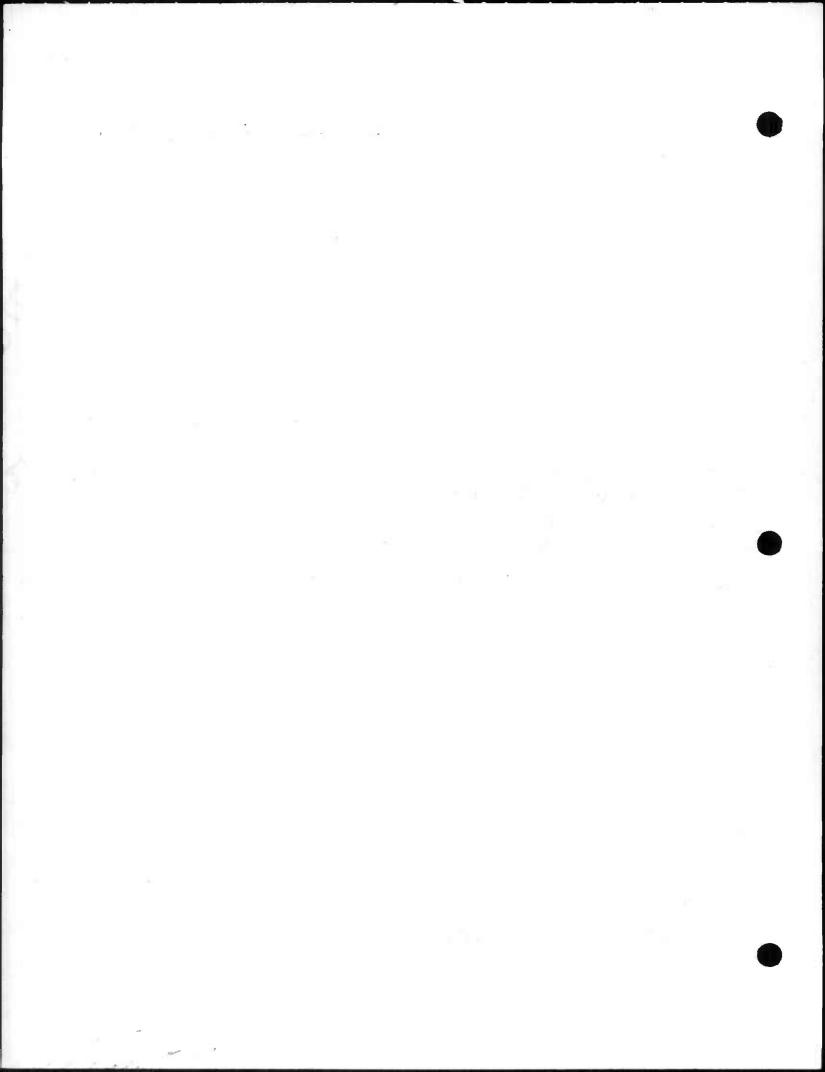
DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examinger must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPAR	TMENT OF H	EALTH AND	MENTA	L HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	Δ		^ .			OF DEATH			3. TIME OF DEAT	ГН	
	Mildred	A		BRIC		TTVG	rech 8		YEAR	21.46	PM	
	4. SOCIAL SECURITY NUMBER		s. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		4 10 2	PLACE (State or Fo	oreign	
	190-30-3595		6 YRS.		HOURS MIN.	JAN	13,19	939 1		SYLVANI	A	
œ	9a. FACILITY NAME (If not institution, give st				OR LOCATION OF D	EATH		9c. COUNT	- 77			
DIRECTOR	WASHINGTON ADVENT	TST HOSPITAL		TAKON	1A PARK			MONTO	JOME	RY		
RE(10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCAT	ION					10d. INSIDE CITY	,	
	MARYLAND ANN 100. STREET AND NUMBER	E ARUNDEL		LAURI						1 🗌 YES 2 💢	NO	
FUNERAL	3444 ANDREW COURT			101	107. ZIP CODE 20724					10g. CITIZEN OF WHAT COUNTRY?		
N I	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S		D 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specific					USA	- American India	•••	
BY F	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 YES 2		If yes, spo	city Cuban, Maxica	an, Puarto	Rican, etc.)		Black, Specify	, White, atc.		
										WHITE		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	USUAL OCCUPATION Work done during model of retired.)	on st of working	168	. KIND OF BUS	INESS/INDU	STRY					
PL	Elementary/Secondary (0-12)	College (1-4 or 5 +)	SECRE				Т	is cor	/FPM	MENT		
S	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First,			VERNMENT			
BE (CHRISTOPHER BASTI	NE			ANN I	MEKI	NE					
2	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street a					lode)			
- [JOSEPH W. BRICE			ANDREW C						724		
	1½ Burial 2 ☐ Cremation 3 ☐ Remo	rval from State complety	cremetory or of	OF DISPOSITION (Na		DAT		CATION CI				
	21. SIGNATURE OF FUNERAL SERVICE LICE	INGEL O	THIND IN	ATIONAL 22. NAME AN	D ADDRESS OF FA	Y 3/1				YLAND HOME, II	10	
	· (alale	Dubada			SANDY SI		ROAD,	LAUR	REL,	MD 2070	07	
	23. PART I. Enter the diseases, or cashock, or heart felium. L	emplications that plused the let only one cause on each	theath. Do n	ot enter the mod	de of dying, suc	h ss cen	diec or respir	retory srre	st,	Approxima		
	IMMEDIATE CAUSE (Finei	0.4	-							Interval Be Onset and		
	disease or condition										ths	
_	DUE TO (OR AS A CONSEQUENCE OF).) 13 Months											
CERTIFICATION	If sny, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):											
CA	CAUSE (Disease or Injury											
Ë	that initisted events resulting in death) LAST	DUE TO (OR AS A CON	ISEOUENCE OF	י):								
B	d									-		
AL	PART II. Other significent conditions	contributing to death but no	ot resuiting i	n the underlying	ceuse given in	Part i.	24s. WAS AN / PERFORI			WERE AUTOPSY FIL		
PHYSICIAN: MEDIC							1 TYES 2	₩ NO		COMPLETION OF COMPLETION OF C	AUSE	
M	DID TODACCO LICE CONTR	UDITE TO CALLET OF D							'	1 - YES 2 - N	10	
AN	DID TOBACCO USE CONTR			H (Check only one)	UNCERTAIL	и <u>П</u>		-				
SIC	EXAMINER?	HOSPITAL:		OTHER:	5 □ Reeldance	0 D Otho	- (Pacatha)					
Ĭ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c, INJU	JRY AT		SCRIBE HOW IN	JURY OCCU	RED			
BY	1 Natural 5 Pending 2 Accident Investigation	(1101111, 154), 164)		M 1 Y							- 1	
COMPLETED	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — As building, etc. (Specify)	t home, farm, a	treet, factory, office		28f. LOC City	ATION (Street ar or Town, State)	nd Number or	Rural Ro	oute Number,		
Ę	29a. CERTIFIER (Check only	IAN: To the best of my knowledge	death occurre	d at the time date	and place, and due	to the car	rea(a) and man					
N N		: On the beals of examination and								and manner as st	ated.	
	296. SIGNATURE AND TITLE OF CERTIFIER	A 4			29c. LICENSE NUI		T			Month, Day, Year)		
TO BE	Mark Allen	MAZER MI	>,		D36	704	-	Mair		, 1995		
	30. NAME AND ADDRESS OF PERSON WHO MGVEAILEN MAZER	COMPLETED CAUSE OF DEATH (7600 C	Print) WASHI	UGTON Ad	Jent,	Park Hor	RIPI	7.5	0		
	31. MAR 1 (Mg/11), 1995	32 PEGRYRAR'S GNATUR	F		1 10000	/1	,	. 13	20	912		
	MHI T = 1999	A DIVINOST TOTAL										



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the truncal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove in the model of the complete that the marked, or filled 23 shows any injury, or other traumatic event, the medical examples must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND		T OF HEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	70/00			2. DATE OF DEATH DO NONTH DO		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 215-24-8988	5. SEX 6. AGE (In yrs. Ia	MONTHS	ER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) AUG. 26,1	928 BIRT Coun MA	HPLACE (State or Foreign try) RYLAND		
TOR	9a. FACILITY NAME (If not institution, give to LAUREL REGIONAL I	,	9b. CI	TY, TOWN OR LOCATION OF D LAUREL	EATH	9c. COUNTY OF PRING	CE GEORGE		
DIRECTOR	10a. STATE 10b. COUNT	Y DWARD	10c. CITY, TOWN	OR LOCATION ELKRIDG	E	10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER 6636 WASHINGTON 1			10f. ZIP CODE 21227		10g. CITIZEN OF USA	CITIZEN OF WHAT COUNTRY? USA		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3XXWidowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 V YES 2 IF YES, GIVE WAR OR DATES 1946-1947	RMED 13	I. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 X NO Speci					
LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) (Cottege (1-4 or 5 +)	ECEDENT'S USUAL Give kind of work done b. Do NOT use retired. SALES	e during most of working		SINESS/INDUSTRY			
COMPLET	12 17. FATHER'S NAME (First, Middle, Last) LORING R. BOYCE			ME (First, Middle, Maiden	PARTS Sumame)				
TO BE	19a. INFORMANT'S NAME (Type/Print) CHERYL BYRD			SS (Street and Number or Rural ING LANE #10			0 20700		
	20e. METHOD OF DISPOSITION 1	20b. PLACE	AND DATE OF DISPO	SITION (Name of HINGTON CREM	DATE 20c. LOG	CATION — City of TO	own, Stata		
-	21, SIGNATURE OF FUNERAL SERVICE LA	Sulada	22	7601 SANDY S	FLECK 1	FUNERAL H	HOME, INC.		
	23. PART . Enter the diseases or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on each neg	eeth. Do not ente	er the mode of dying, suc	h as cerdiec or reapi	retory erreat,	Approximeta interval Between Onset and Death		
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Chronic obstanctive fulmonary disease. Respiratory failure Is days Chronic obstanctive pulmonary disease. Is gents Cor pulmonary disease. Jenus disease or Injury that initiated events resulting in death) LAST Cor pulmonary Due to (DR AS A CONSEQUENCE OF): d.								
ÄL	PART II. Other eignificent condition	e contributing to deeth but not	reaulting in the u	inderlying ceuse given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	O. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	ATH YES CE OF DEATH Chec		N 🗆		1 TYES 2 NO		
BY PHYSIC	t VES 2 NO 27. MANNER OF DEATH 1 No Natural 5 Pending Investigation	HOSPITAL: 1 Inpetient 2 ER/Outpatient 3 26e. DATE OF INJURY (Month, Day, Year)	OTHE 4 No. 28b. TIME OF INJURY	R: unsing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO	6 Other (Specify) 26d. DESCRIBE HOW IN	JURY OCCURED			
	3 Suicida 6 Could not be determined	28s. PLACE OF INJURY — At he building, etc. (Specify)	ctory, office	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	one) 2 MEDICAL EXAMINE	ICIAN: To the best of my knowledge, de IR: On the basis of examination and/or					a) end mennar as stated.		
TO BE	296. SIGNATURE AND TITLE OF CERTIFIES DB. NAME AND ADDRESS OF PERSON WA	O COMPLETED CAUSE OF DEATH (ITE	M 27) (https://www.	D 39	532	≥ 3//3	/15		
	Timothy M	CLAIN MD	321 Pri	nce George	St. Laure	eno:	20707		

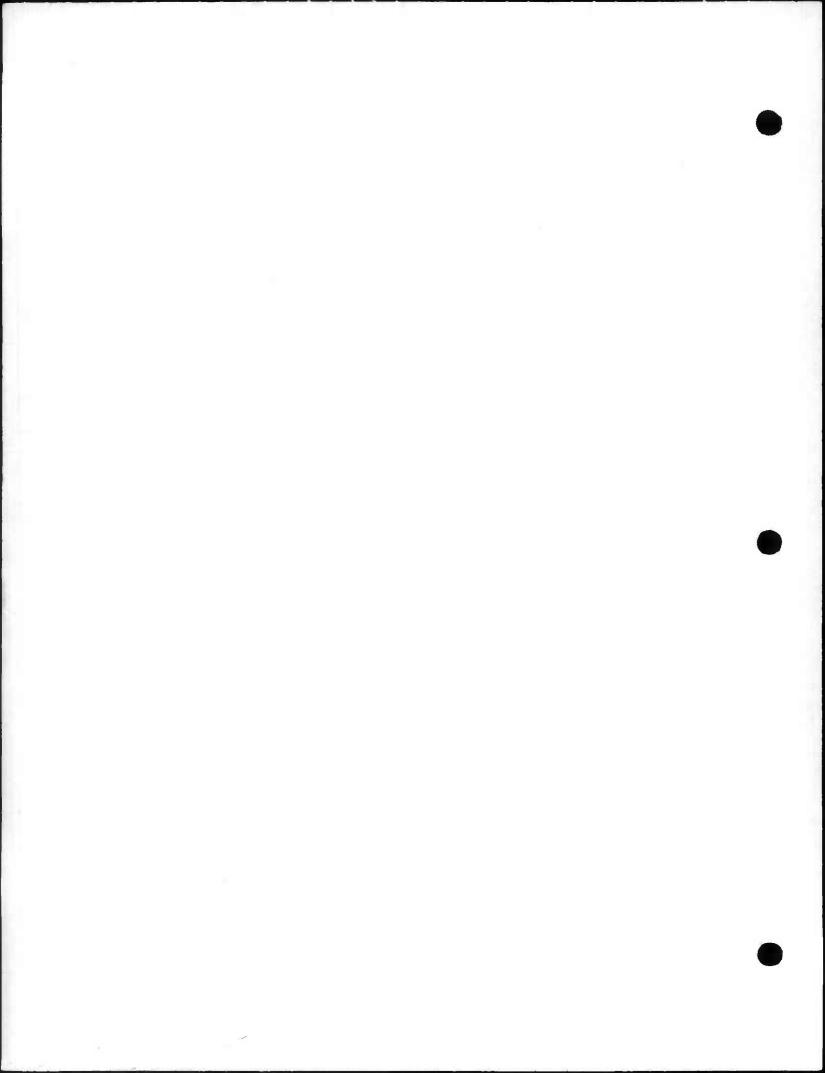
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

	REGISTRAR		CE	RTIF	ICATE OF	DEAT	ГН		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	DEATH	-		3. TIME OF DEA	тн
	LEROY J.	BARTI	HLOW					MARCH	11,	^ 1995	YEAR	5:50	Ам
	4. SOCIAL SECURITY NUMBER 5	s. SEX	6. AGE (in yrs. las	t birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF				PLACE (State or F	
	217 20 3000	1 X M 2 □ F	67	YRS.	MONTHS DAYS	HOURS	MIN.	JULY		927	Country	yLAND	
~	9e. FACILITY NAME (If not institution, give street				9b. CITY, TOWN	OR LOCATIO	ON OF DE	EATH		9c. COU	NTY OF DE	ATH	
DIRECTOR	HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD												
Ä	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10c									10d. INSIDE CIT	Υ		
5	MARYLAND HOWA	RD			COLUMBI	A						LIMITS?	NO
AL	10e. STREET AND NUMBER			1	r. ZIP CODE	E	·		10g. CIT	IZEN OF W	HAT COUNTRY?		
FUNERAL	10113 DONLEIGH DR					210					U.S.	Α.	
E	11. MARITAL STATUS 1:	2. WAS DECEDENT FORCES? 1]	EVER IN U.S. AR	MED	13. WAS DE	CENDENT O	F HISPAN	NIC ORIGIN? (Specify Yes	or No-	14. RACE Black	- American Indi	len,
Β¥	3 Widowed 4 Divorced	NAVY				2 X NO			ii, wii		Specif		
8	15. DECEOENT'S EOUCAT	ION	16a. DE	CEOENT'S	USUAL OCCUPAT	ON		16b, KI	ND OF BU	SINESS/INE	DUSTRY	WILLE	
Fi	(Specify only highest grade cor Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	Do NOT us	work done during me retired.)	ost of workin	ig TC	1 200		GTON,			
COMPLETED		4		ERVIS	OR, ROC	OKDIN M	16			OR CO		•	
ő	17. FATHER'S NAME (First, Middle, Last)					_	IER'S NA	ME (First, Mide			JOICE		
BE (UNKNOW	N						UNKNO	WN				
6	19e. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADORESS (Street	and Number	or Rural F	Route Number,	City or Tow	n, State, Zip	Code)		
-	YOLANDA DEMONTE		10)117	DONLEIG	H DRI	VE,	COLUM	BIA,	MD.	2104	6	
	20s. METHOD OF DISPOSITION 1 Buriel 2 Cremellon 3 Remova	al from Stale	20b. PLACEA	ND DATE	OF DISPOSITION (A	ame of		DATE		CATION —			
	4 Donation 5 Other (Specify)		ST. JO	SEPH	CEMETE	RY 3	3-15-	-9 5	NIA	GRA E	FALLS	, NEW YO	RK
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE				ND ADDRES					. 11.5		
	Malles 1	1/0.0-	_		STERL	ING A	SHTO	ON FUN	ERAL	HOME	E, IN	C. D. 2122	0
	23. PART i. Enter the diseasea, or con	nplications that	ceused the de	eth. Do r	ot enter the m	ode of dyl	ng, suci	h aa cardiad	or reap	ratory an	rest,	Approxim	_
	ahock, or heert fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Drustor Failure												
	DUE DO (OR AS A CONSEQUENCE OF):												
NO	Sequentially list conditions, b. Stime - Brancharyen-												
Ě	thany, leading to immediate Due to (OR AS A CONSEQUENCE OF):												
CERTIFICATION	CAUSE (Disease or Injury												
Ē	that initieted events DUE TO (OR AS A CONSEDUENCE OF): resulting in deeth) LAST												
빙	d												
DICAL	PART II. Other aignificent conditions of	ontributing to d	leath but not re	esulting i	n the underlylr	g ceuse g	lven in	Pert I. 24	a. WAS AN			WERE AUTOPSY F	
8								1	YES 2			COMPLETION DF	
ME												1 YES 2	NO
ä	DID TOBACCO USE CONTRIB	SUTE TO CAL	JSE OF DEAT	TH YE	S 🗆 NO [UNC	ERTAIN	۱ 🗆 ۱					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	28. PLAC	E OF DEAT	H (Check only one OTHER:								
XS	1 YES 2 740	□ Inpatient 2		□ DOA	4 Nursing Ho	ne 5 🗆 Red	sidence	6 Other (S	pecify)				
	27. MANNER OF DEATH 1 Dending	26e. DATE OF II (Month, Day	NJURY (, Year)	28b. TIM	URY	DRK?		26d. DESCR	BE HOW I	NJURY OC	CURED		
B	2 Accident Investigation					YES 2	NO						
8	3 Suicide 6 Could not be 4 Homicide datermined	building, at	INJURY — Al hor tc. (Specify)	ne, farm, s	dreet, lectory, offi	•		28f. LOCATIO	ON (Street e bwn, Stete)	and Number	or Rural Ro	oute Number,	
<u>"</u>	290. CERTIFIER	N. T. db. back of									_		
COMPLET	(Check only one) 2 MEDICAL EXAMINER: C											and manner at	totad
	295 SIGNATURE AND TITLE OF CERTIFIER	2			n, m my opinion,				piece, en				tated.
H	Z SIGNATURE AND THE OF CHILDREN	16	4 5	-		29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED (Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON WHO IS	7	200	27) (%	Print)	UL	-) /	117			-/.	アーシュ	
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. J. ALLIANDI, BY PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PERSON HARDI PROPERTY HARDI PROPERTY HARDING PRINTED PROPERTY HARDING PROPERTY												
7	N. J. GALLANDI,	/51)	8491	RAI	T N.45	1 Du	le.	Ell1	077	Tu	14 1	,	



MARYLAND 21215-0020 BALTIMORE.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN:

Pages 1, 2, 3 should permit. Page 6 may be retained by the hospital or attending physician, at director, page 5 should be detached for use as the burial-transit once. To de notified pe must medicai examiner funeral hours after death. the filled in by 1 0 the completely other traumatic event, executed within burial, and prior to attending physician antal Hygiene prior to requires that the death certificate be 6 Mental injury, the signed by t Health and 23 shows any certificate has been h the State Oept, of AMP Item ! 6 this c marked, . OIRECTOR: After the hours after death was 69 item 28 | TO THE HOSPITAL OF THE FUNERAL OF THE FUNERAL OF THE MITTIN 72 HOSPITANT: If It

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH leon 05 march 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. 6. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH 2/7/1929 1 M 2 T F MARYLAND 218-22-3303 66 YRS 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL BALTIMORE Ho RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MARYLAND 1 X YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21229 314 N. HILTON STREET IISA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. It yee, specify Cuben, Maxicen, Pt 1 YES 2 NO Specify: 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES BY Specify: 3 X Widowed 4 Divorced ARF. AMERICAN COMPLETED 15. DECEDENT'S EDUCATION secify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 12 WES UNSELD SCHOOL DAY CARE MOTHER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) CARRIE GEORGE HINES HINES BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 **JONES** 314 N. HILTON STREET, BALTIMORE, MARYLAND 21229 IRMA 20a. METHOD OF DISPOSITION
1X Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State GARRISON FOREST VA.CEMETERy3/7/95 OWINGS, MILL, MD. Donatton 6 - Other (Specify) 21. SIGNATURE OF SUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217 23. PART I. Enter the diseases, or complications that coded the desth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition_ MYOCARDIAL INFARCTION ACUTE 2 DAYS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DRONARY DISEASE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING · NON-INSULIN DHARFLES CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events MELLITUS reculting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a, WAS AN AUTOPSY PERFORMED? 1 | YES 2 | NO OF DEATH? 1 TYES 2 TNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Reeldence 6 - Other (Specify) 27. MANNER OF BEATH 28e. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Investigation BY Accident PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(e) end manner es stated (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Youg) 29c. LICENSE NUMBER BE gwadlanhan CCU RESIDENT MARCH 2ND 20 95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ST AGNES HOSPITAL 900 S. GATON AVE BAUTO MD 2/229 DR. WADTAVKAR

AMERICAN CHRONINE



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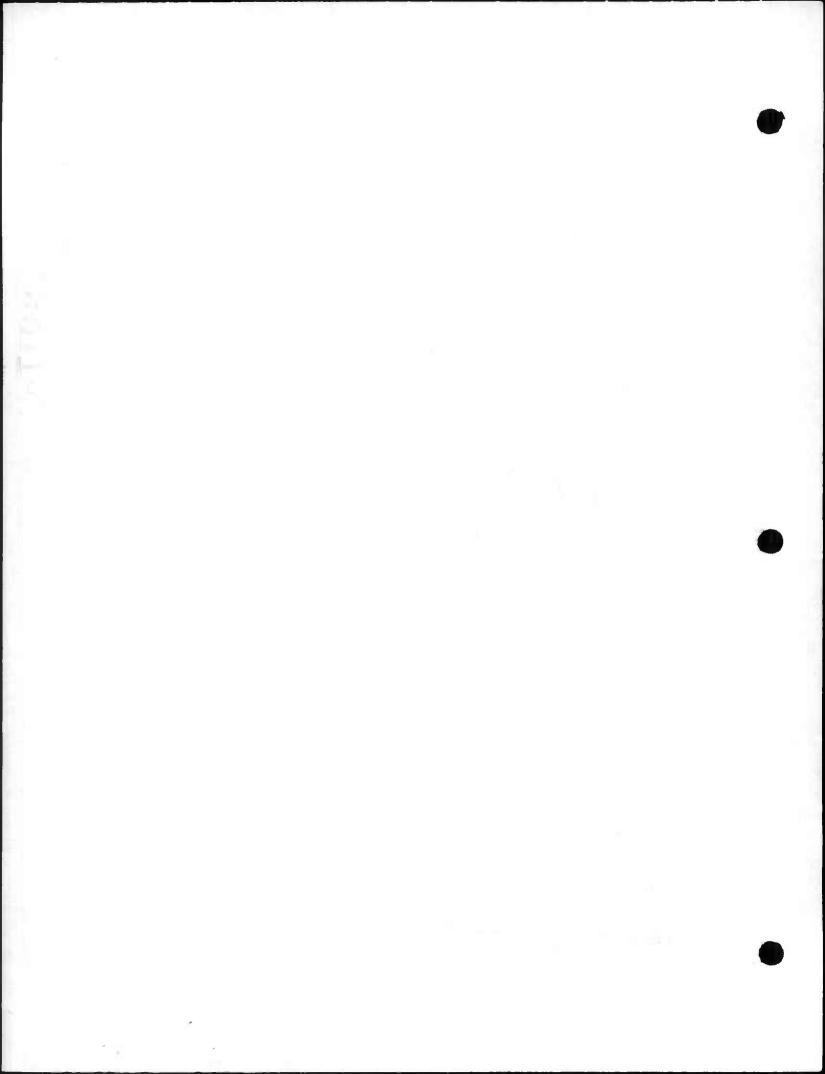
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ING PHYSICIAN: The law requires that the death certificate be executed within four after the may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the trimer of the trimer plane 1.2 a.s.	after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or manner	marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law	TO THE FUNERAL DIRECTOR: After this certificate has I	be filed within 72 hours after death with the State Dept	IMPORTANT: If item 28 is marked, or Item 23	

pinor

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC			MENTAI	HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Last)			J. (1 L O	DEATH	2. DATE	OF DEATH		3. TIME OF DEAT	,	
	CLASSIE BR	ITTO				MONTH 3		95		ш	
				IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	6, Bil	RTHPLACE (State or For	reign	
	231-40-2042	1 🗆 M 2 🟋 89	YRS.	ONTHS DAYS	HOURS MIN.	10	7107190)5 HÃ	LIFAX, N. C		
	9a. FACILITY NAME (If not institution, give street	et end number)		b. CITY, TOWN	OR LOCATION OF E	DEATH	Т	9c. COUNTY O			
DIRECTOR	42 N. ELLAMONT ST	REET		BALTI	MORE		1	ROL	L C41		
[[RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		100 0077	TOWN OR LOCAT				Dal	10 0114		
ਵ	MARYLAND RAH	0.7						10d. INSIDE CITY			
	10e. STREET AND NUMBER	10 (1)	BA	LTIMORE		40 - 0/7/7/7/4	1 X YES 2 1	NO			
8	42 N. ELLAMONT ST	PEET		100	21229		1	USA	F WHAT COUNTRY?		
FUNERAL		2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC OBIGIN	/Snacify Van		ACE — American India		
	1 Never Married 2 Merried	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Maxic	an, Puerlo R	icen, etc.)	81	ack, White, atc.	n,	
ВУ	3 🕅 Widowed 4 🗌 Divorced			ny.		ARF	AMERICA	N			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working							1		
W.	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use i	retired.)			. /	10			
₩.	10	1	DOMESTI	C WORK	ER		House	E Ker	PEL		
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, M	liddle, Meiden Si	umame)	9		
BE	G BARRY GARY			CLARA		ILLARD			-		
2	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural						
	MARY G. COLE 42 N. ELLAMONT STREET, BALTIMORE, MD. 21229										
	20s. METHOD OF DISPOSITION 1 CyBurial 2 Cremation 3 Gremoval from State 4 Donatton 5 Dother (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of commercing of commercin										
	21. SIGNATURE OF FUNERAL SERVICE LICEN	GEF CI	EDAR HILL		ID ADDRESS OF F		BROOM	CLYN, M	ARYLAND		
	W. 11 h.	9)11			BROTHE		NERAL I	HOME, P.	Α.		
	W 17.	Vsle	/	1300	EUTAW P	LACE,	BALTI	MORE, M	D. 21217		
1	23. PART I. Enter the diseases, or con shock, or heart fellure. Lis	nplications that caused it only one cause on ea	the death. Do not	entar the mo	da of dyling, suc	ch aa card	ac or reapire	itory arrest,	Approxima		
	IMMEDIATE CAUSE (Final) Onset and Death										
	resulting in deeth)	disease or condition resulting in deeth) a. Coronary artery Difference of:									
	DUE TO (OR AS A CONSEQUENCE OF):									ian	
S	Sequentially list conditions. 1. 14 Merters in 20 years										
CERTIFICATION	til any, laading to immediata cause. Enter UNDERLYING										
윤	CAUSE (Disease or injury that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):								
E	resulting in death) LAST									- 1	
	d										
AL	PART II. Other algolificant conditions of	ontributing to death bu	t not resulting in	the undarlying	cause given in	Part I.	24a. WAS AN AL	FDA	4b. WERE AUTOPSY FIN		
MEDIC							1 YES #	V	COMPLETION DF CA OF DEATH?		
ME							/	1	1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIB	JUTE TO CAUSE OF	DEATH YES		UNCERTAI	N 🗆					
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	6. PLACE OF DEATH	(Check only one)							
YS		☐ Inpetient 2 ☐ ER/Outpe		☐ Nursing Hom		6 🗆 Other	(Specify)				
표	27. MANNER OF DEATH 1 Matural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C			28d. DE\$0	CRIBE HOW INJ	URY OCCURED			
B	2 Accident Investigation				ES 2 NO						
ED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	— At home, term, atre (y)	et, tectory, office		28f. LOCA City o	TION (Street end Town, State)	d Number or Rura	al Route Number,		
릴		N: To the best of my knowle									
COMPLET	one) 2 MEDICAL EXAMINER: C	In the basis of examination	and/or investigation,	in my opinion, de	eath occured at the	time, date o	end place, end	due to the ceus	e(e) end menner ee sta	ted.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	-1.10			29c. LICENSE NU	MBER	- 1	29d. DATE SIGNI	ED (Month, Day, Year)		
TO B	24/10	2 m			039	102	-	▶ 3/	10/95	-	
F	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Pri		. In	~ -	. /	-			
	6713 ovea	in stol	Sethmu	e w	1021.	22	4				
	31. DATE FILED (MONEY DIPO 195	og recontacts som	Iori								
	minit I					/				- 1	



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

4GSPTAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. F within 72 hours after death with the State Dent, of Health and Memal Hydiere brior to burial, cremation, or removal.	TANY: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TAL DR ATTENDING PHY	AL DIRECTOR: After this 72 hours after death wil	if Item 28 is marke
4OSP	VITHIN	ANT

ges 1, 2, 3 should

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 08,1995 WILLIAM AVON BAILEY MARCH 16:51 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) FEB. 22, 1919 8. BIRTHPLACE (State or Foreign DAYS HOURS 579-07-3817 1X M 2 | F YRS 76 VIRGINIA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1100 BLK. CARROLL ST. BALTIMORE BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYLAND BALTIMORE CITY BALTIMORE 1 X YES 2 NO FUNERAL 10a STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1162 CARROLL STREET 21230 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO IF YES, GIVE WAR OR DATES WW II 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, 1 Never Married 2 X Married 1 YES 2 NO BY 3 Widowed 4 Divorced Specify: Specify: WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify College (1-4 or 5+) H/S GRAD CARPENTER McMILLIN LUMBER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) HAROLD O'NEIL BE MARY WARWICK 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. RUTH BAILEY 1162 CARROLL STREET - BALTIMORE, MD 21230 20a_METHOD OF DISPOSITION
1 ☑Burla1 2 ☐ Cremation 3 ☐ Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State GLEN HAVEN MEMORIAL PARK 4 Donation 5 Other (Specify) _ 3/13 GLEN BURNIE 21. SIGNATURE OF FUNERAL SERVICE AICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. an 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23. PART I/Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ehock, or heart fellure. Liet only one ceuse on each line. intervai Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ AKTERIOSCIEKOTIC CAMEDIOVASCULAR DIRETASE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMEO? 1 YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: XXYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Xother (Specify) ON STREET 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF GEATH 28b. 28c. INJURY AT 1 Nstural TIME OF 26d. DESCRIBE HOW INJURY OCCURED 5 Pending 1 YES 2 NO BY Investigation Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicida 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of marknowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of on and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCME MARCH 09,1995 2 HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GOLW JR MY 111 PENN STREET BALTIMORE, MARYLAND 21201

TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: If Item 21

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

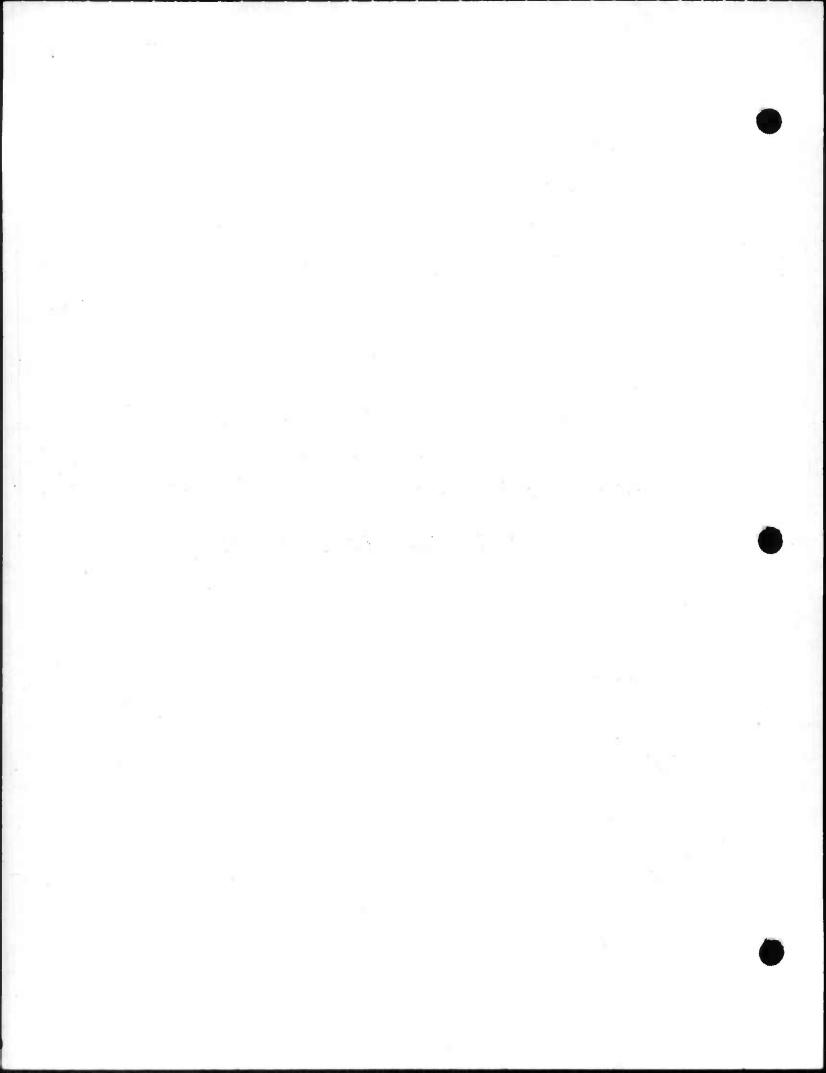
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

	REGISTRAR			CHIIL	ICALE	= Or	DEATH	REG. N	O.			
	1. DECEDENT'S NAME (First, Middle, Last) Ella Mae Bro	พท							DAY	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. la:					3 12	2	95	10,00H M	
	212-22-9859	1 M 2 TF		4 YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1 - 15 - 21		8. BIRTI	NPLACE (State or Foreign ry) VA	
	9e. FACILITY NAME (If not institution, give s	street and number)			9b. CITY	b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEAT						
æ	4700 Harford	Rd					timore		1	n/a		
DIRECTOR	RESIDENCE OF DECEDENT						OTMOTE			11/	а	
H	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN C	OR LOCA	TION				10d. INSIDE CITY	
	MD	n/a			Bal	lti	more				LIMITS?	
AL	10e, STREET AND NUMBER			10	f. ZIP CODE	10g. CITIZEN OF			WHAT COUNTRY?			
FUNERAL	1010 W. Baltin				21223	US			SA			
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEI 1 Name Marital 3/7/Married FORCES? 1 VES 2 PONO				13.	WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Y	e or No-	14. RAC	E — American Indian, k, White, atc.	
	1 Never Married 2 Married	IF YES, GIVE WA		NO			city Cuban, Maxica 2 NO Specif	in, Puerto Ricen, etc.)		Spec	the:	
В	3 Widowed 4 Divorced						T CLEEN Specific	,		Spec	Black	
	15. DECEOENT'S EDU (Specify only highest grade	CATION	16a, OE	CEDENT'S	USUAL O	CCUPATIO	ON	16b. KIND OF B	JSINESS/IN	IDUSTRY		
ᇤ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	Do NOT us	vork done (ne retired.)	during mo	ast of working	-24 37 3110				
릴	12			Dom	esti	ic			Home	e Ma	ker	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTNER'S NA	ME (First, Middle, Maide				
	Lloyd Royson							erdie P1		or		
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street s		Route Number, City or To				
٩	Barbara Harris	S						Baltimo			21216	
	20a. METNOD OF DISPOSITION											
	20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE 20c. LOCATION — City or Town, Stata 20b. PLACE AND 20b. PLACE AND DATE 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DISPOSITION Name of 20b. PLACE AND DATE OF DAT										* * *	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
- 1	James A. Morton & Sons Fune									neral Home		
	James	U. 1150	2001	ν	17	701	Lauren	s St. Ba	lto.	M	D 21217	
NO	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. END STAGE CORD DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
ਹ	PART ii Other significant condition											
EDICAL	PART II. Other algnificant condition	-AUCE!	C put not r	esulting I	n the un	deriying	g ceuse given in	Part I. 24a. WAS A PERFO	RMED?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME									-1		1 TES TO	
	DID TOBACCO USE CONTI	RIBUTE TO CAU	ISE OF DEA	TH YE	S \square N	10 E	UNCERTAIL	V 🗆			_ /41	
Ĭ.	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT								
SE	EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA	OTHER		e 5 Decidence	8 Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF II		28b. TIMI		28c. INJ		28d. OESCRIBE HOW	INJURY OF	CLIBEO		
	1 Natural 5 Pending	(Month, Day	Year)	INJ		WO	RIC?	and. Objectible flow	moon oc	CONEO		
面	2 Accident Investigation 3 Suicide & Could not be	28a PLACE OF	INJURY — At ho	me ferm s	drant factor			and I control (or			1.	
COMPLETED	4 Nomicide 6 Could not be determined	bullding, et	c. (Specify)	, territ, a	ureet, racte	огу, отно		261. LOCATION (Street City or Town, State	and Numbe	r or Rumil F	loute Number,	
글	29e. CERTIFIER 1 CERTIFYING PNYSI	CIAN: To the best of m	y knowledge, de	eth occurre	d at the th	me, date	and place, and due	to the cause(e) end me	nner ee sta	ted		
፮	one) 2 MEDICAL EXAMINE) and menner as stated.	
	29b. SIGNATURE AND TITLE OF CENTURE					_						
8	cuerfaris	are M	0				D 160	19	1	APC	(Month, Day, Year) # 14, 1995	
2	30. NAME AND ADDRESS OF PERSON WHI	O COMPLETED CAUSE	OF DEATH (ITE	N 27) (Type,	Print)	DAI	PNAV	5T. BA	T. 1	no	2/221	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CAVELLA - SOARES 100 N. BROAD WAY ST. BAFT. NO. 21231 31. DATE FILEO (Month, Day, Vear) 22. REGISTRAR'S SIGNATURE											
	MAK I 4 1995	w forwarden	artelle									



Pages 1, 2, 3 should

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funeral director, page 5 should be detached

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DIRECTOR: /

FUNERAL within 72 |

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(687	e executed within 2
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REC	requires
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TA	The
OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760	AL OR ATTENDING PHYSICIAN: The law requires that the death certificat
	S
_	SPITAL

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARY BYRNE 11:17 am ANNINA Mar 10 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) Aug. 29,1910 BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 - M 2 F 218-76-4755 DAYS HOURS YRS Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Saint Joseph Medical Center Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Maryland Baltimore Baltimore 1 YES 2XXNO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 6401 N. Charles St. 21212 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black. White, etc. Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: Specify: 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION ETED. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) llege (1-4 or 5+) COMPL Coll.4 Teacher Education 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme Ti Charles Philip Byrne BE Margaret Mary McFadden notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sister Bernice Feilinger 6401 N. Charles St. Balto. Md. 21212 9 20s. METHOD OF DISPOSITION

KXBurial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Villa Maria Cemetery 4 Donation 5 Other (Specify) 3/13/95 Glen Arm.Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Inc. Robert M. Kratz 6500 York Rd. 21212 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition ____ 20 HOURS SEPSIS. event, DUE TO (OR AS A CONSEQUENCE OF): ACUTE DIVERTICULITIS traumatic 20 HOURS CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) thet initiated events reaulting in death) LAST 0 PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? CHRONIC ISCHEMIC HEART DISEASE, ARTERIOSCLEROTIC 1 TES 2 NO OF DEATH? CARDIOVASCULAR DISEASE 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) MOSPITAL:

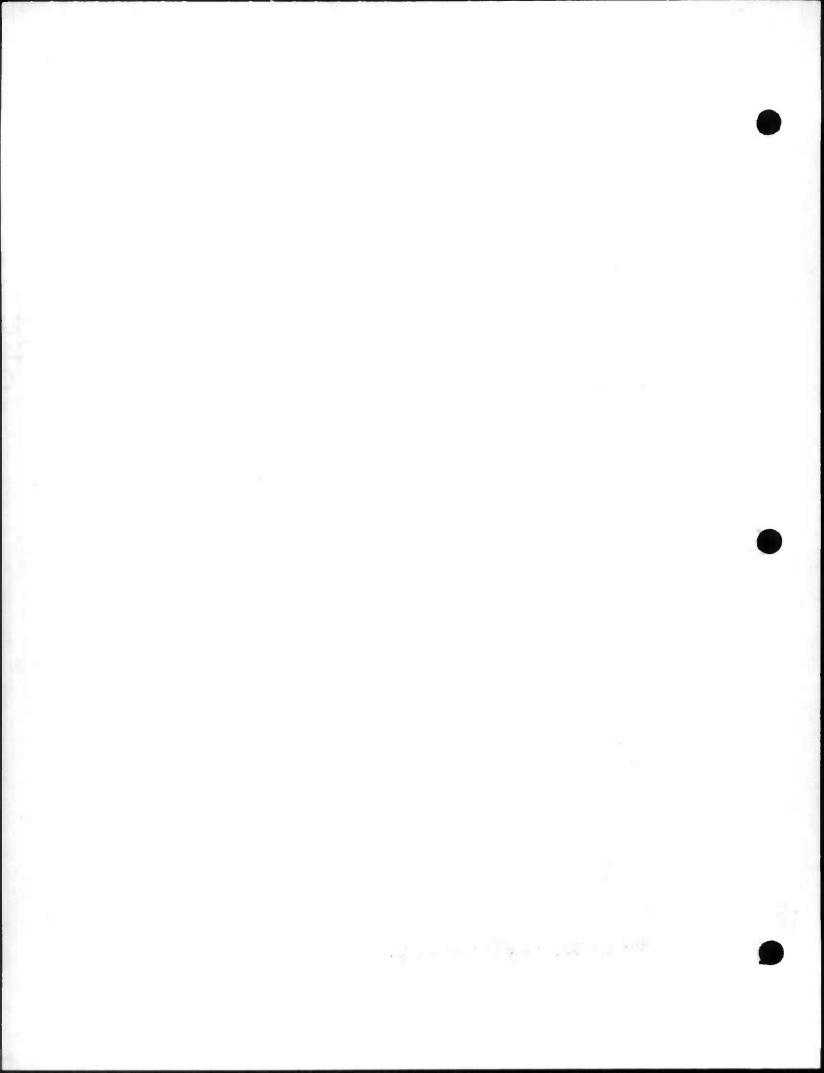
1 Dinpetient 2 ER/Outpetient 3 OTHER: 1 TES 2 NO DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED marked. 1 Netural 5 Pending м 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) .69 ETED. 8 Could not be 4 🔲 Homicide 28 determined 29e. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. (Check only one) = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the besie of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE allis mar.10.1995 nous D16492 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEATRIZ P. DIZON, M.D., ST. JOSEPH MEDICAL CENTER, 7620 YORK RD., TOWSON, MD. 21204 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S GIGNATURE

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. The hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA	ENT OF HEALT	H AND ME	NTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3. TIME OF DEATH	
	Edna B. Bun	ch			1.5	arch 9.	1995	2.05 P M	
	4. SOCIAL SECURITY NUMBER				ER 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year)		IPLACE (State or Foreign	
	219-32-0195	1 🗆 M 2 💢 F	73 YRS.	ITHS DAYS HOURS		ctober 16.		,, ebraska	
~	9e. FACILITY NAME (If not institution, give	street and number)	96.	CITY, TOWN OR LOCA	TION OF DEATH		9c. COUNTY OF E		
2	859 Woods Road			Pasadena			Anne A	rundel	
120	859 Woods Road Pasadena Anne RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Md. N/A Baltimore								
븝	Md.	N/A	Balt	imore				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
AL.	10s. STREET AND NUMBER			10f. ZIP CO	DE		10g. CITIZEN OF		
FUNERAL	931 W. Lombard	St.		2	21223		US	SA	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	V.S. ARMEO	13. WAS DECENDENT			or No- 14. RACI	- American Indian,	
BY I	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, OIVE WAR OR D	ATES	If yes, specify Cui		uerto Ricen, etc.)	Spec	th/·	
ED E	15. DECEDENT'S EDI	ICATION	16a. OECEDENT'S USU	AL COCUMATION		T		white	
	(Specify only highest gred	College (1-4 or 5+)	(Give kind of work life. Do NOT use ret	done during most of working.)	king	166. KINO OF BUS	INESS/INOUSTRY		
7	6	N/A	Homema	aker		Own Hom	10		
COMPLET	17. FATHER'S NAME (First, Middle, Last)		TTOMOTIN		THER'S NAME (First, Middle, Maiden			
ш	Charles Edwar	d Tindle			earl K				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO ADD	PRESS (Street and Numb	oer or Rural Route	Number, City or Town	, State, Zip Code)		
	Ada V. Brown			ds Road, P	asaden	a, Md. 2	21122		
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetign 3 Ren	noval from State 20b	PLACE AND DATE OF OI	SPOSITION (Name of Nece)		140	CATION — City or To	.,	
. 3	4 Donation 5 Other (Specify)		Sten Haven	Memorial 22. NAME AND ADDR			n Burnie	, Md.	
	and the state of t	The A					Home of	Elk., Inc.	
- 8	Vary	d. Nout	nens	5695 Main	St I	F]kridae	Md 21	.227	
	23. PART I. Enter the diseases or shock, or heart failure.	complications that couled List only one cause on e	the deeth. Do not e	enter the mode of d	lying, such as	cardiac or reapir	ratory arreat,	Approximata Interval Between	
	IMMEDIATE CAUSE (Final disease or condition	1idal.		11-	lind.			Onset and Death	
	resulting in death)	a covery	nerasio	stic 1	aose	y Cas	ncer		
_		OUE TO OFFAS A	CONSEQUENCE OF):		0				
ဋ်	Sequentially list conditions, if any, leading to immediate	b. OUE TO (OR AS A	CONSEQUENCE OF):						
8	cause. Enter UNDERLYING CAUSE (Disease or injury	¢-							
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	resulting in death) LAST	d							
AL C	PART II. Other significant condition	ns contributing to death b	ut not resulting in th	e underlying ceuee	given in Pert	1. 24s. WAS AN /	WTOPSY 24b	WERE AUTOPSY FINDINGS	
						PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC						1 🗌 YES 2	ermo	OF DEATH?	
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	NO D UN	CERTAIN [1 YES 2 NO	
SI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (C	heck only one)					
Sic	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp		HER: Nursing Home 5/01	Rasidence 6 🗆	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	280	. DESCRIBE HOW IN	JURY OCCURED		
B	1 Netural 5 Pending 2 Accident Investigation			M 1 TYES 2	□ NO				
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, ferm, street ify)	, factory, office	28f	LOCATION (Street or City or Town, State)	nd Number or Rural F	oute Number,	
COMPLETED	AN OFFICE								
MPI	(Check only CERTIFYING PHYS	SICIAN: To the best of my knowl							
8		ER: On the basis of sxamination	snd/or investigation, in				due to the ceuse(s	and manner as stated.	
BE	296. SIGNATURE AND TOLE OF CENTIFIE	MI		29c. Lie	CENSE NUMBER	20	29d. DATE SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON W	O COMPLETED CAUSE OF DE	TH (ITEM 27) (Sma Prim	0	1020	30	3/1	135	
	SATTAN A	- MALICA	22	South a	reeso	St	Ballin	Die MAN	
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE	2.000 4		1-0.	D00-40	ou jav	
	MAR 1 4 1995	Seli Asimi.	Pas u			,		21202	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CER	HIFICA	IE OF	DEATH		REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) PRESTON	BRA	BRANNAN						2. DATE OF DEATH MONTH DAY GEAR 7:30)				
			AGE (In yrs. lest birth	MONT	HOER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, L	Day, Year)	1	B. BIRTN Countr	IPLACE (State or Foreign y)		
	215-16-5389 9e. FACILITY NAME (If not institution, give stree	1 X M 2 D F	73 <u> </u>	RS.			March	1, 19	22		ryland		
OR	Bon Secours Hosp				arv, rown o altimo	OR LOCATION OF DE	EATH			NTY OF D	EATN		
딥	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY		
DIRECTOR	Md.	N/A			ltimor						LIMITS?		
FUNERAL	100. STREET AND NUMBER 1427 McHenry St.				101	21223			VNAT COUNTRY?				
BY FUN	1 Never Married 2 Merried	12. WAS DECEDENT E FORCES? 1 V	VER IN U.S. ARMED YES 2 NO OR DATES		If yes, sp	ENDENT OF NISPAN ecify Cuben, Mexice 2 NO Specify	n, Puerto Ric	Specify Yes an, atc.)	or No—	USA 14. RACE Black Speci	— Americen Indian, c, White, etc.		
	3 Wildowed 4 Divorced		<u>Korean</u>								white		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION Impleted)	(Give kir		L OCCUPATION MO		16b. K	ND OF BUS	INESS/IND	USTRY			
ا۳		College (1-4 or 5 +)						F 2	4				
M	UNKNOWN 17. FATHER'S NAME (First, Middle, Lest)	N/A		buote	sterer	18. MOTHER'S NA		Furni	_				
ŭ	John Joseph Brann	an				Mamie			Surname)				
BE	19s. INFORMANT'S NAME (Type/Print)	idii	19b. MA	ILING ADDR	IESS (Street a	nd Number or Rural I			State Zin	Codel			
2	Patrick J. Branna	n				St., Bal							
1	20e, METNOD OF DISPOSITION		20b. PLACE AND D	ATE OF DISI	POSITION /Ne	me of	DATE	20c. LO	CATION —		wn. State		
ł	1 Burlel 2 X Cremellon /3 Remove 4 Donation 8 Other (Specify)	al from State	The Gre	en Mo	ount (Cemetery	3/10		ltim				
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /	8	0	22. NAME AN	D ADDRESS OF FA	an Fun	eral	Home	of	Elk., Inc.		
-	23. PART I. Enter the diseeses or cor	d - N. O.	ufman	7 5	695 M	lain St.,	Elkr	idge,	Md.	21			
	shock, or heert failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	c A	On each line.	1 A		4 4		c or reepi	ratory err	•st,	Approximate interval Between Onset and Desth		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):												
	PART ii. Other significent conditions	contributing to de	eth but not result	ting in the	underlying	ceuse given in	Part i. 24	e. WAS AN		24b.	WERE AUTOPSY FINDINGS		
EDICAL	() AdvAnced	COP	\bigcirc		A -1:		1	PERFOR		-	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
밀	@ Chronic Dan	d aw	te ren	kel f	Allu	'e				1	1 YES 2 NO		
	DID TOBACCO USE CONTRIB	BUTE TO CAUS	E OF DEATH	YES [NO [UNCERTAIN	N 🗆						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	28, PLACE OF	_									
YSI		inpatient 2 EF	NOutpatient 3 🗆 D	OA 4 🗆		e 5 🗆 Residence	8 Other (S	(pecify)					
H H	27. MANNER OF DEATH	28e. DATE OF INJ (Month, Day,		TIME OF	28c. INJ	URY AT RK?	28d, DEŞCR	IBE NOW I	JURY OCC	URED			
B	1 Natural 5 Pending 2 Accident Investigation			M		rES 2 NO							
COMPLETED	3 Suicide 8 Could not be determined	28e. PLACE OF IN building, etc.	IJURY — At home, fo (Specify)	erm, street,	fectory, offici	•	28f. LOCATI City or	ON (Street e Town, State)	nd Number	or Rurel R	oute Number,		
2 1	290. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my	knowledge, death or	corred at It	ne time, date	end place, end due	to the cause	e) end man	ner as state	ed.			
ŏ.	one) 2 MEDICAL EXAMINER:										end menner as stated.		
	296. SIGNATURE AND TITLE OF CERTIFIER	A .	4 0			29c. LICENSE NUN					(Month, Day, Year)		
TO BE	CPKO	4Mey 1	M			D278	360		▶ 3	3/8/	95		
F	30. NAME AND ADDRESS OF PERSON WHO CO	D KEN	ARWEY	(Type, Print)	7	00 W/T,	H R	3200	B	AZI	nep		
	31. DATE FILMARY 1 4"1995	32 AEGISTRAR'S	SIGNATURE	1		-				-	2123		

1 -1. D

9a. Ma

RE 10a Ma 10e.

Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events

resulting in death) LAST

29s. CERTIFIER

FUNERAL DIRECTOR

BY

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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	9	Tel.	E E	
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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely. In by the fu	be filed within 72 hours after death with the State Dept. of Hearth and Mental Hyglene prof to bunal, cremation, or removal.	
	TO	TO	e a	
	=	F .	0	

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

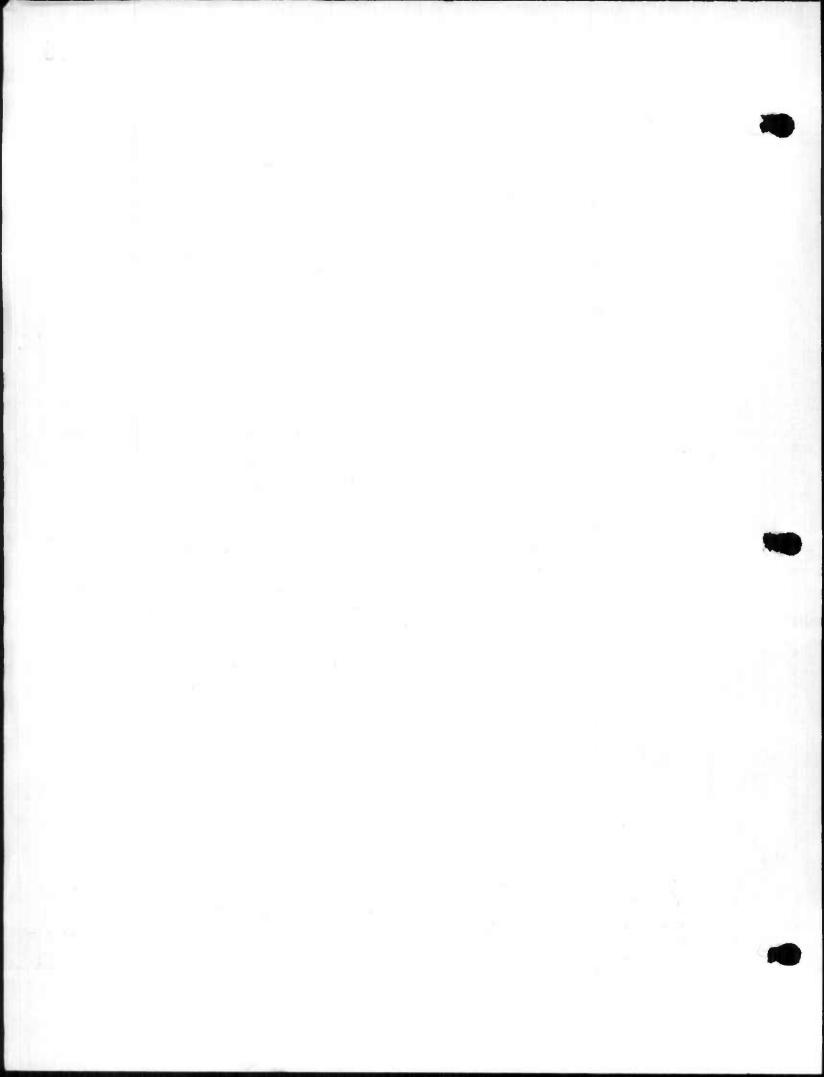
												95	0/583	
FOR STATE REGISTRAR		STATE OF M	MARYLAN	ID / DEP	ARTM IFICA	ENT OF	HEALTH F DEAT	AND		YGIENI EG. NO.	E			
1. DECEDENT'S NAME (First, Middle, Last)					3 ARTH 2. DAT MON						× –	95AR	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER 216-32-3910	(Morth Day Year)						936	s. BIRTHPLACE (State or Foreign Country) West Virginia						
90. FACILITY NAME (# not in Maryland Mai	nor Co		nt Cer	nter			or LOCATION	ON OF D	EATH			INTY OF E	undel	
RESIDENCE OF DEC	10b. COUNTY	,	-	100	CITY TO	WN OR LOC	ATION						10d. INSIDE CITY	
Maryland		Arundel				Burni							1 YES 2 NO	
10e. STREET AND NUMBER							101. ZIP CODI				10g. CIT	IZEN OF	WHAT COUNTRY?	
803 Paradis	e Lane						2106	1		4	Uni	ted	States	
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES											k, White, atc.			
15. DEC	EDENT'S EDU	CATION completed)	1	Se. DECEDEN	IT'S USU	S USUAL OCCUPATION 15b, KIND OF BU					ISINESS/INDUSTRY			
Elementary/Secondary (College (1-4 or 5	+) I	(Give kind of work done during most of working life. Do NOT use retired.) Factory Worker				Food Production						
17. FATHER'S NAME (First, A	tiddle, Last)		-				18. MOTI	HER'S NA	AME (First, Middle	, Maiden	Sumame)			
Alva J. Pars	sons						Els	ie K	Katheri:	ne M	ulli	.ns		
19s. INFORMANT'S NAME (Type/Print)			19b. MAIL	ING ADD	RESS (Stree	et and Number	or Rural	Route Number, C	ity or Town	n, State, Zi	ip Code)		
Howard Bart	h			4164	1 Ho	11ins	Ferr	y Ro	d., Bal	timo	re,	Mary	land 21227	
20s. METHOD OF DISPOSITION 1					DISPOSITION (Name of commeter), cremetory or March 11, 1995 Catonsville, March Catonsville, March 11, 1995									
22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E., Glen Burnie, MD 21061														
23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final														
disease or condition resulting in death)														

PART II. Other algnificant conditions contributing to death but not resulting in the underlying 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 11 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 6. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA 1 YES 2 NO 5 Residence 8 Other (Spec/ly) 28s. OATE OF INJURY (Month, Day, Year) 27. MANNED OF OEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At homs, term, street, tectory, office building, stc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 4 Homicide

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as atated.

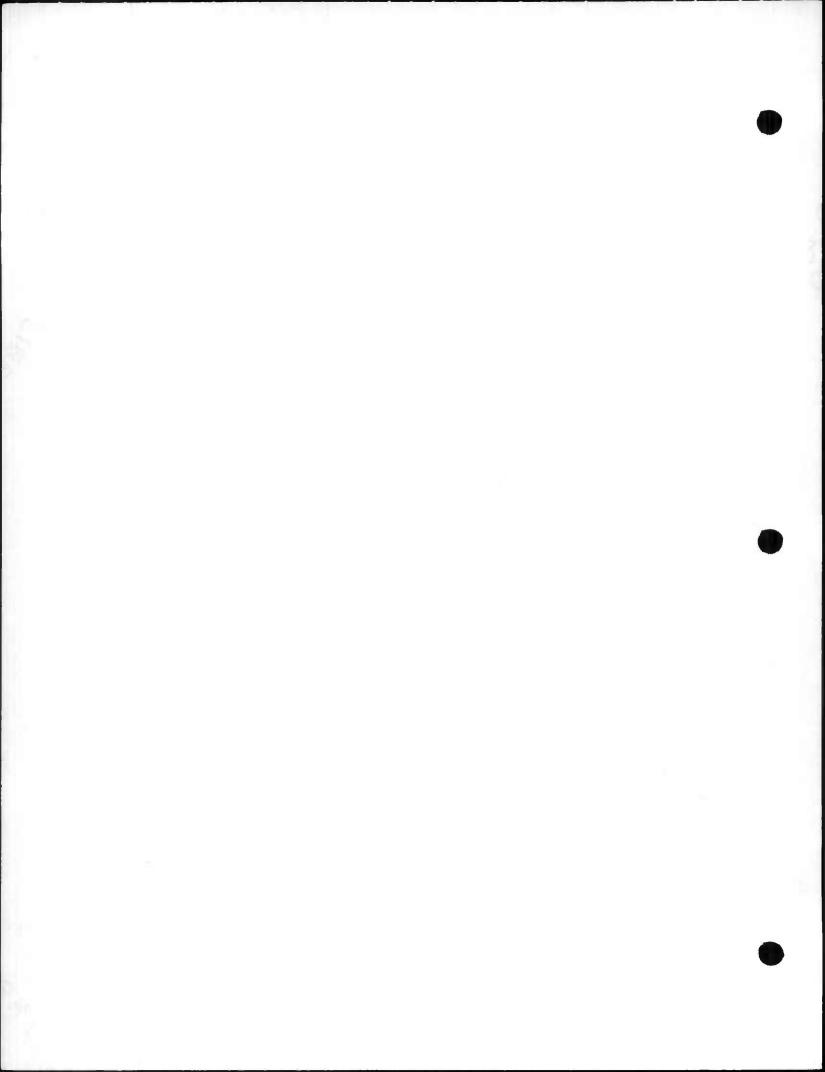
2 🔲 MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Dry D. Spartely M.D.	D29767	+ 3/11/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	418 B+A B1	VI. Pasadong, M.



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		1 - STATE REGISTRAR	STATE OF I		/ DEPAR					MENTAL HYGIE!			
		1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH)AY	YEAR 3.	TIME OF DEATH
		CARRIE 4. SOCIAL SECURITY NUMBER	G.						MARCH 12 1995 9:50			9:50 A M	
P		214-24-3771	5. SEX 1 M 2 X F	6. AGE (In yrs. Is 76	YRS.	IF UNDER	DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRTH 9/23/18	V	Country)	ACE (State or Foreign . nia
2, 3 should	CTOR	90. FACILITY NAME (If not institution, give MARYLAND GENERAL						IMORI		ATH	9c. COUNT	N/A	
- -	EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN (OR LOCAT	ION				1 10	Id. INSIDE CITY
permit. Pages	DIRE	Maryland	n/a			Ba1t							LIMITS?
usit .	FUNERAL	3124 Gwynns F	alls Pa	rkway			101.	ZIP CODE 212				USA	AT COUNTRY?
21215-0020 If or attending physician. For use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. WAS DECEOEN FORCES? 1 IF YES, GIVE V	YES 2 X	RMED NO	1 1	If yes, spe	cify Cuban	F HISPANI , Mexican Specify:	C ORIGIN? (Specify Ye , Puerto Rican, etc.)	s or No—	14. RACE — Black, W Specify:	American Indian, India, etc. Black
1215 r attend use as	ED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. D	ECEDENT'S	USUAL O	CCUPATIO	N st of working	,	16b. KINO OF BU	SINESS/INDU	STRY	
	COMPLET	Elementary/Secondary (0-12) 12th	College (1-4 or 5	+)	Stoc				,	Hut	zler'	S	
MARYLAND 2- retained by the hospital of 5 should be detached for notified at once.	BE CO	17. FATHER'S NAME (First, Middle, Last) Salanda	Davenpo	rt						NE (First, Middle, Malden	Surname)		
	TO B	19a. INFORMANT'S NAME (Type/Print) Cecelia Collii	ns	11	3124	GW	(Street ar	rd Number o	or Aural A	PKWY • B	m, Stata, Zip C	ode) , Mc	1. 21216
BALTIMORE, I is after death. Page 6 may be n by the funeral director, page removal.		20e. METHOD OF DISPOSITION 1	ovel from State	20b. PLACE	AND DATE	OF DISPOS	ITION (Nar	me of	22 28	1 .	CATION — CI		State
Page al dire		21. SIGNATURE OF FUNERAL SERVICE LI		ALD	1	22.	NAME AN	O ADDRES	S OF FAC	ILITY			
BALTIMO after death. Page 6 by the funeral direct moval. cal examiner mu		I.EROY O. DYETT & SON FUNERAL, HOME 4600 I.IBERTY HEIGHTS AVENUE 21207 23. PART Ever the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, Approximate											, HOME 21207
within 24 hour pletely filled is remation, or ent, the me		IMMEDIATE CAUSE (Final	a. ARPER	ise on each lin	·0710	CA				as cerdlec or reap		it,	Approximate Interval Between Onset and Death
BOX 68: cate be execute thysician and or e prior to buria	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	(OR AS A CONSE	Hereco G								
ORDS, F that the death d by the atter o and Mental my Injury, o	ICAL (PART II. Other aignificent condition	s contributing to	death but not	reaulting	in the un	derlying	cause gl	ven in F	Part I. 24s. WAS AN			RE AUTOPSY FINDINGS
RECORDS, P.O. w requires that the death certify to been signed by the attending ptr. of Health and Mental Hygien 3 shows any Injury, or oth.	MEDIC									1 YES 2		CO OF	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?
	ä	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	ATH YE	S 🗆 1	40 🗆	UNCE	RTAIN				
一年 自 音	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEAT	OTHER							
. 5 E E	HYS	1 X YES 2 NO 27. MANNER OF OEATH	1 Inputient 2X		DOA 28b. TIM		ang Home			Other (Specify) 28d. DESCRIBE HOW I	N HIPW OCCU	250	
ION OF NDING PHYSIC The this ce the death with the Is marked,	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, D			URY M	WOF			zou. DESCRIBE NOW I	NJORT OCCU	NEU	
	8	3 Suicide 8 Could not be determined	28e. PLACE O building,	F INJURY — At he atc. (Specify)	ome, farm, s	treet, tacti	ory, office			26t. LOCATION (Street City or Town, State)	and Number or	Rural Route	Number,
DIRE DIRE	PLE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge, de	ath occurre	d at the ti	me, date a	and place, e	end due t	o the cause(a) and ma	nner as stated		
HOSPITAL FUNERAL within 72 h	COMPLET	one) 2 X MEDICAL EXAMINE											d manner ea stated.
TO THE HOSPII TO THE FUNER be filed within	TO BE (2914 SUBJETURE AND TITLE OF CERTIFIES	Tolle	An	1			O.C.		BER	MARCH	I I3,	1995
		MAKIO TO GOLLE	O COMPLETED CAUS	DE OF DEATH (ITE	M 27) (Type, PENN	Print) STRE	ET,E	BALTII	MORE	,MARYLAND	2120)1	
		MAR 1 4 1995		R'S SIGNATURE									

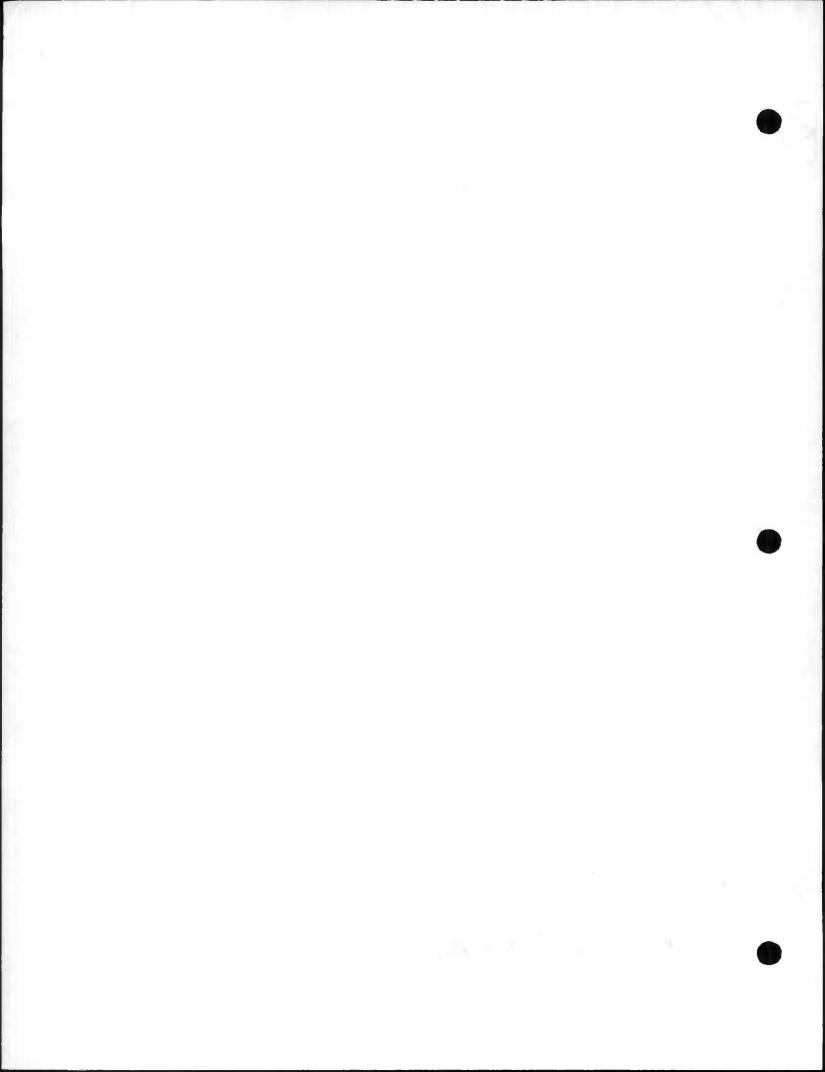


BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	ENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

1.	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF HEALTH AND	MENTAL	HYGIENE REG. NO.			
1.	DECEDENT'S NAME (First, Middle, Last)				2. DATE O			3. TIME OF DEATH	
	Wendell	H. Beard	en		Mar.	1 1 °	1995	11:59 A	
4.	SOCIAL SECURITY NUMBER			F UNDER 1 YEAR IF UNDER 24 HRS	7. DATE OF	BIRTH		PLACE (State or Foreign	
	231–58–1373	1X M 2 G F 81 YRS. MONTHS DAYS HOURS MRN. (Month, Day, Year) Country) Tenness							
g 3		30 N. Leisure World Blvd. Apt.427 90. CITY, TOWN OR LOCATION OF DEATH Silver Spring 9c. COUR							
10·	De. STATE 10b. COUNT	Y	10c. CITY. 1	TOWN OR LOCATION				10d. INSIDE CITY	
	Maryland	Montgomery		Silver Sprin	g 	<u> </u>		LIMITS?	
- III	3330 N. Leisure V	World Blvd. A	orld Blvd. Apt. 427					HAT COUNTRY?	
S 11 ''	. MARITAL STATUS Never Married 2 X Married Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 \(\subseteq YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DECENDENT OF HIS It yes, specify Cuben, Men 1 YES 2 XNO Spe	ican, Puerto Ric	(Specify Yes or No an, atc.)	Specify Yes or No.— 14. RACE — American Indian, Black, White, atc. Specify: White		
	15. DECEDENT'S EDU (Specify only highest grade	completed)	16s. DECEDENT'S US (Give kind of worl life. Do NOT use n	k done during most of working	16b. K	IND OF BUSINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Accounta		I	Federal G	overn	ment	
BE CO	r FATHER'S NAME (First, Middle, Last) Charles Bearden				NAME (First, Mide e Sands	Idle, Maiden Surneme)			
A 190	Mary A. Bearden ((Spouse)	19b. MAILING AE 3330 N.	DRESS (Street and Number or Ru Leisure World	Blvd.	Silver S	princ	0906 Maryland	
12	De. METHOD OF DISPOSITION Disposition S C Other (Specify)		PLACE AND DATE OF 1	pisposition (Name of piece) March	15,199	20c. LOCATION -	City or To	un, State	
21.	SIGNATURE OF EUNERAL SERVICE TH			22. NAME AND ADDRESS OF	FACILITY				
-	Verrusen	Della .		Leroy M & Ru 1630 Edmonds					
1	snock, or neart tellure.	List only one ceuse on e	the deeth. Do not ech line.	enter the mode of dying, s	uch ss cerdie	c or respiratory sr	rest,	Approximate Interval Between	
iM di: re:	shock, or heart fellure. MMEDIATE CAUSE (Final lacese or condition esuiting in deeth) dequentielly list conditions, any, leeding to immediate ause. Enter UNDERLYING AUSE (Disease or injury nat initiated events esuiting in deeth) LAST	S. Produce on e	ech line.	enter the mode of dying, s					
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DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing 5 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State begin of Health and Mental Hygher prior remainion, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other transmatte event, the medical examines must be medical examines must be medical examines.

	1 - FOR STATE REGISTRAR	TE OF MARYLAND		TMENT OF H		MENTAL HYGI				
	1. DECEDENT'S NAME (First, Middle, Last)		BRUECKITANN			2. DATE OF OEATH DAY YEAR 3. TIME OF OEAT MONTH DAY YEAR 3. TIME OF OEAT MOULEL 915 3. TIME OF OEAT MOULE 915 3. TIME 915			TIME OF OEATH 3 50 PM	
		M 2 □ F 86	last birthday) YRS,	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, You) Jan. 18	1909	Country) Mary		
TOR		9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital 9b. CITY, TOWN OR LOCATION OF DEATN Columbia						9c. COUNTY OF DEATN HOWard		
DIRECTOR	10s. STATE 10s. COUNTY HOW	Howard 10c. CITY, TOWN OR LOCATION Ellicott Cit				10d. INSIDE CI LIMITS?				
FUNERAL	3805 Portman Place			101	101, ZIP CODE 21042			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
B	1 Never Married 2 - Married FOI	S DECEDENT EVER IN U.S. RCES? 1 TYES 2 Y YES, GIVE WAR OR DATES	ARMED	If yes, spi		ANIC ORIGIN? (Specify Yea or No — 14. RACE — American Indican, Puerto Rican, atc.) 14. RACE — American Indican, atc.) Black, White, etc. Specify:			American Indian, hita, etc.	
COMPLETED	The state of the s	ge (1-4 or 5 +)	(Give kind of w life. Do NOT us		st of working	111200000000000000000000000000000000000	BUSINESS/IND			
BE COMP	12 17. FATHER'S NAME (First, Middle, Last) Adolph C. Brueckmann		ectric.	cal Engi	18. MOTHER'S NA	ME (First, Middle, Mell Childress		Contra	ctors	
TO B	19a. INFORMANT'S NAME (Type/Print) Alice Brueckmann (S					Route Number, City or Licott C:			21042	
	20e. METHOD OF DISPOSITION 1 Seurial 2 Cremation 3 Removal from 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES	m Stata 20b. PLAC cemetery, c Prov	cremetory or ot 1dence		rch 14,1		amber,			
	· Lusewan	itte		Leroy	M & Russ	ell C Wit	atones	71110		
	23. PART I. Enter the diseases, or complice shock, or heart failure. List only IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ly one ceuse on each li	ne.				apiratory arr	eat,	Approximate Interval Between Onset and Death	
CATION	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR AS A CONS	3 57	ROKES					> 2 years.	
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST d									
MEDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the undarlying causa given in Part I. 24a, WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH?						ALABLE PRIOR TO WPLETION OF CAUSE			
AN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	1 YES 2 NO 1 Ing	PITAL: patient 2 KER/Outpatient	3 🗆 DOA		5 🗆 Rasidence	8 Other (Specify)				
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ETED.	4 Homicide determined	4 Homicide detarmined							"Number,	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the								I manner as stated.	
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	•			2.0	0469	▶ h	e signed (Moi	1th, Day, Year) 9th 1995	
	M. R. VELLAMEI; 9	655 CHEV	(Kale	T DRIVE	# 100	o . elli	GTT	City.	110.21042	
	MAR 1 4 1995 Julia dan	REGISTRAR'S SIGNATURE								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JAMES** WILLIE BRISON FEB 1995 4:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 5-2-03 DAYS HOURS 578-24-6457 91 LAUREN CO. S.C. 1 M 2 | F Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number; 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR WICOMICO RIVER SALISBEURY WICOMICO 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. MICOMICO SAL ISBURY 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1106 TUSCOLA AVE. be detached for use as the burial-transit 21801 USA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yea, specify Cuban, Maxican, Puarto Ricar

1 YES 2 NO Specify: 1 Never Merried 2 Married Specify: ВУ 3 X Widowed 4 Divorced Specify: BLACK ETED 15. DECEDENT'S EDUCATION ecity only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spe College (1-4 or 5+) COMPL 7th LABORER PENINSULA GEN'L HOSP. (RET) once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ JOHN RELFORD BRISON MARTHA ELLA ELEDGE BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 7603 KOWAN AVE., SALISBURY, MD. 21801 BEATRICE FOUNTAIN pe 9 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of Раде 6 тау 20c. LOCATION - City or Town, State DATE must °SALISBURY°CREMATORY 2 - 11SALISBURY. MD. 4 Donation 6 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 7213 JERSEY ROAD, SALISBURY, MD. 21801 death. JOLLEY MEMORIAL CHAPEL executed within 24 hours after of n and completely filled in by the 1 to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on such line. Approximata Interval Batwean **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition _ DROWNING COMPLICATING ATHEROSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the attending physician I Mental Hygiene prior to certificate be e. Enter UNDERLYING CAUSE (Disease or Injury that initiated events other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 Injury, PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS been signed by the AMPLABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? shows any DIABETES MELLITUS 1 PAYES 2 NO 1 WES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Z PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate t EXAMINER? L DIRECTOR: After this certificate bours after death with the State HOSPITAL OTHER: Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 YOther (Specify) 6 RIVER 26a. DATE OF INJURY For (Month / Day, Year) 27. MANNER OF DEATH 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural м SUBJECT FELL INTO RIVER 1 YES 2 NO BY 2 X Accident 26s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State) L. Comic C. Rivel Hear C+50, Sales Luy L. 69 3 Suicide 6 Could not be COMPLETED 28 4 Homicide datermined WICOMICO RIVER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) end menner as stated. (Check only one) HIAL N N = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Chute Jemis 40 0 CME FFR 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 4 1995 Devoler Rardall

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27. MANNER OF DEATN

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DIVISION OF VITAL RECORDS, P.O.	SPITE OR ATTENDING PHYSICIAN: The law requires that the death certific	WHA DIRECTOR: After this certificate has been signed by the attending pt in A hours after death with the State Dept. of Health and Mental Hyglene
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95 07590 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH MAIN 50 Frank Bradford 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) Oct.11,1914 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign MONTHS DAYS 219-30-3484 1 X M 2 - F 80 HOURS YRS. Harford Co., Md 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH Harford Memorial Hospital Havre De Grace Harford RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Carroll Westminster 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3628 Bixler Church Road 21158 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 3 Widowed 4 Divorced 1 YES 2 X NO Specify: White 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 8 Farm Manager Md.School for the blind 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Thomas Alexander Bradford Deborah Baldwin 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4329 Madonna Rd. Street, Md. 21154 Mrs. Barbara Decker 20a. METHOD OF DISPOSITION
1 □ Burlal 2 Ø Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State corpetery, cremetory or other place) Metro Crematory 3/10/95 4 Donation 5 Other (Specify) Baltimore.Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home 6. 11750 Belair Road Kingsville, Md. 21087 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Finei** Onset and Death Septicema 9 disease or condition resulting in death) 4days DUE TO (OR AS A CONSEQUENCE OF): Pneumonia 10 clays Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING 1 oct Traur CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 - YES 2 NO 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TYES 2 NO

28a. DATE OF INJURY

OTHER:
4 □ Nursing Nome 5 □ Residence 8 □ Other (Specify) Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

28e. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

3/10/95

29s. CERTIFIER
(Chack only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE-OF CERTIFIER 29c. LICENSE NUMBER

D 32609

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Mith ani. Revolutionst. thousen and 703 avre De Gran MD 21078

31. DATE FILED (MOTER, DEN) 100'S 1VI AR 1 4 1995" MAR 1

Investigation

6 Could not be

Whilman

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BALTIMORE, MARYLAND	retained
	2
Ï	may
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≥	Page
AL	death.
n	after
	hours
00	within 24
1 28/1	executed
5	2
P.O. BOX 68760	tath certificate be executed within 25 hours after death. Page 6 may be retained by the hospit
7	ath

21215-0020

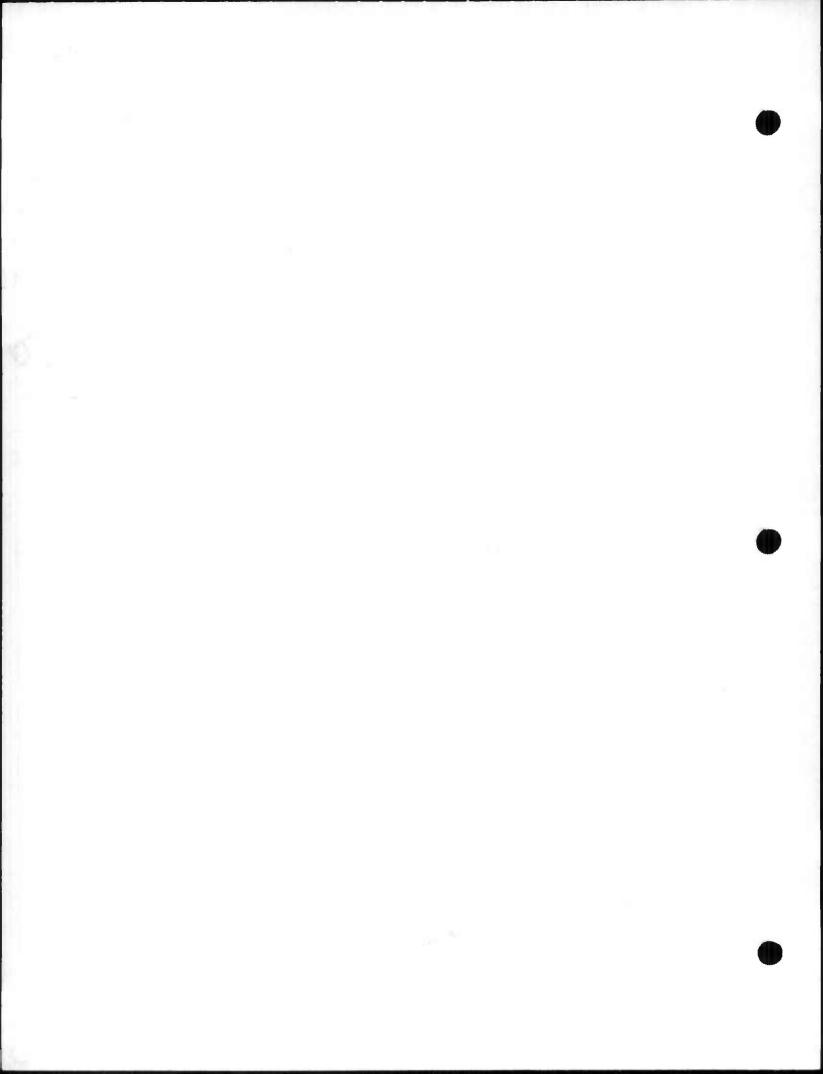
DIVISION OF VITAL RECORDS, P.O.

	1 - FOR STATE REGISTRAR	TE OF MARYLAND .	/ DEPART	MENT OF	HEALTH AND	MENTAL	HYGIENI REG. NO.	E		
10	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATN			3. TIME OF DEATH
	Viola Catherine	Coffey				Marc	h 12,		YEAR	3:30 Pm
	4. SOCIAL SECURITY NUMBER 5. SEX			IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTN , Day, Year)		8. BIRTN	PLACE (State or Foreign
		² x ^F 75	YRS.	DATE DATE	HOURS MIN.		25,19	919 1		land
	9a. FACILITY NAME (If not institution, give street and i	number)	8	b. CITY, TOWN	OR LOCATION OF	DEATN		9c. COUNT		
DIRECTOR	104 Roundup Road Middle River Baltimore							re		
Ä	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION				T	10d. INSIDE CITY
ā	Maryland Baltimore			Middle	River					LIMITS?
A	10e. STREET AND NUMBER				f. ZIP CODE			10g. CITIZI	EN OF W	HAT COUNTRY?
FUNERAL	104 Roundup Road				21220			II	.S.A	
ا ج		DECEDENT EVER IN U.S. A			CENDENT OF NISP				4. RACE	- American Indian, White, stc.
BY		ES, GIVE WAR OR DATES			NO Specify Cuban, Maxie		iican, etc.j			white
	15. DECEDENT'S EDUCATION									wifice
	(Specify only highest grade completed	d) ((Give kind of wor to Do NOT use i	SUAL OCCUPATI rk done during m	ON ost of working	16b.	KIND OF BUS	INESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0-12) College	e (1-4 or 5+)	House				Н	me		
OM	17. FATNER'S NAME (First, Middle, Last)		HOUDE	MIIC	18. MOTNER'S N	AME /First M				
O I	Richard Brady					rietta		lider		
00	19a. INFORMANT'S NAME (Type/Print)	11	9b. MAILING A	DDRESS (Street	and Number or Rura				Code)	
유	Carl A. Coffey				oad Midd					21220
	20a. METHOD OF DISPOSITION	20h. PLACE	ANDDATEGE	DISPOSITION /N	ame of	DATE	200 100	ATION - CI	the on Ton	on Clate
- ji	1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	Holly	Hill Hill	Mem. G	ardens 3	3/15/9	5 Balt	imore	co co	unty, Md.
	21. SIGNATURE OF FUNERAL SERVICE-LICENSEE	0		22. NAME A	ND ADDRESS OF F	ACILITY				Carey Ji Ras
	1 ta 13	rate 14			zinski F					
	23. PART I. Enter the diseases, or complice shock, or heart fellure. List only	tions that cadeed the d	leath. Do not	anter the me	de of dying, su	AVE B	altimo	atory srre	lary st,	land 21221 Approximate
	IMMEDIATE CALICE (Final	The state of the s		/			,			Onset and Death
	disesse or condition resulting in death)	METAST	ATIC	- M	EAST	C4	WCE	M		1 years
		DUE TO (OR AS A CONSE	EQUENCE OF):							
8	Sequentially list conditions,	DUE TO (OR AS A CONSE	OUTNOT OF							
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DOE TO ON AS A CONSE	OUENCE OF):							İ
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSE	EOUENCE OF):							-
	resulting in death) LAST									
- 11	DART II ON A MILE									
MEDICAL	PART II. Other significant conditions contri	buting to death but not	resulting in	the underlyin	g cause given li	n Part I.	24a. WAS AN A PERFORA		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă						<	1 YES 2	X NO		COMPLETION OF CAUSE OF DEATH?
Ξ					/					1 ☐ YES ZXXNO
ÿ	DID TOBACCO USE CONTRIBUTE				UNCERTA	IN 🗆				
호	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSP			(Check only one)						
PHYSICIAN:		atient 2 ER/Outpatient 3	3 🗆 DOA 4	☐ Nursing Non	e 5 Rasidenca	_				
- 100	27. MANNER OF DEATN 284	(Month, Day, Year)	28b. TIME (Y WO	URY AT	28d. DESC	CRIBE NOW IN	JURY OCCU	IRED	
2 Accident Investigation 3 Suicide 6 Could not be detarmined 28. PLACE OF INJURY — Al home, farm, street, factory, office building, stc. (Specify) 28. PLACE OF INJURY — Al home, farm, street, factory, office City or Town, State)										
							oute Number,			
9	29a, CERTIFIER		_					-		-
M b	(Check only									
800	2 MEDICAL EXAMINER: On the	O TAXABILITY AND OF	investigation,	in my opinion, i	eath occured at th	e time, data a	and place, and	dua to tha	cause(a)	and manner as stated.
# 4	296. SIGNATURE AND TITLE OF CENTIFIER	X AND	1		29c. LICENSE NU	MBER	,	29d. DATE	19750 E	Month pay, yar3
2	30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED, CAUSE OF DEATH (ITE	M 27) (5	rine)	V3.	1//		1	1	995
	11toAn 1. 5	NAVOS	M 21) (lype, Pr		712/	SIL!	Tall	MA	my	LAND
	31. DIEF BO MONA PROCE JUL 32	Hartan Karlet	-		NA.	W)	. 0/0	0	-/	
	WHU T # 1999 0 00							MG	47	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit; Pages 1, 2, 3 should	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	d, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
we executed within	an and complete	r to burial, crem	umatic event,	
ath certificate t	tending physici	al Hygiene prio	or other tra	
ires that the de-	signed by the at	lealth and Ment	vs any injury,	
e law requi	has been s	Dept. of H	1 23 shov	
ICIAN: Th	certificate	the State	, or Item	
DING PHYS	After this (death with		
OR ATTEN	DIRECTOR:	ours after	tem 28 la	
TO THE HOSPITAL	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with	IMPORTANT: It item 28 is mark	

	1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPART	MENT OF H	EALTH AND	MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Peggy	Jean	CRAIC	GHEAD		March 1	DAY 1995	7:26 p m		
				F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	- 1	BIRTHPLACE (State or Foreign Country)		
	213-34-0010	1 M 2 X F 58	YRS.	ONTRS DATE		Oct.7,193	6	Tennessee		
OC.	Se. FACILITY NAME (If not inetitution, give street		9	b. CITY, TOWN O	R LOCATION OF DE	EATH	9c. COUNT	TY OF DEATH		
DIRECTOR	Franklin Square Ho	spital		Ro	ssville		Baltin	nore County		
Ä	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d, INSIDE CITY		
	Maryland Balt	imore	1	Essex				LIMITS?		
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?		
Ä	57 Stemmers Run Ro				21221			S.A.		
교	11. MARITAL STATUS 1 1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	₹ NO	If yes, spe	cify Cuban, Mexica	HC ORIGIN? (Specify 1 in, Puerto Rican, etc.)	les or No- 1	4. RACE — American Indian, Black, White, etc.		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	3	1 TYES	2 NO Specify	y:	1	Specify. White		
G	15. DECEDENT'S EDUCAT (Specify only highest grade co.	FION 16	. DECEDENT'S US	UAL OCCUPATIO	N -	16b. KIND OF B	USINESS/INDU:	STRY		
<u> </u>		College (1-4 or 5+)	life. Do NOT use r					25		
COMPLETED	10		Factory	Worker		Cup Man	utacto:	ring Company		
	17. FATHER'S NAME (First, Middle, Last) Horace Craighead					ME (First, Middle, Maide Hewitt	n Surname)			
BE	19e. INFORMANT'S NAME (Type/Print)									
임	Marianna Craighead					Poute Number, City or To				
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION //Name of CATE 20c. LOCATION - City of Them. State									
	1 Donation 5 Other (Specify)	d from State carneters	enmount	Cremato	ory 3/16		ltimore			
	23 SIGNATURE OF FUNERAL SERVICE LICEN		/	22. NAME AN	O ADDRESS OF FA	CILITY				
	Janu 6	magazin				uneral Ho ern Ave.Ba				
	23. BART I. Enter the diseeses, or con	nplications that caused the	e deeth. Do not	enter the mod	de of dyling, auci	h aa cardlac or rea	piratory arrea	re, MD. 21221		
	ahock, or heart fallure. Lis	it only one ceuse on eech	line.					Interval Between Onset and Death		
	disease or condition resulting in death)	CALDIAC	Dane	THUM	8			212		
		DUE TO (OR AS A CO	NSEQUENCE OF):	1	Deal			743		
NO	Sequentially list conditions, b.	DUE TO (OR AS A CO	4 1/1	tay.	LYCOS	E		lys		
AT	if any, leading to immediate cause. Enter UNDERLYING	TV O	QUENCE OF):					20.		
윤	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A COI	NSEQUENCE OF):	701				nego		
CERTIFICATION	resulting in death) LAST									
	PART II. Other algolficent conditions of	contributing to death but a	of seculting in	lbo undortulos	acues alues to	Beat Lee man		1		
S S	HYPEURIS	OK)	or resulting in	ine underlying	ceuse given in		N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDI	MANUC:	RENAL F	Allur			1 TYES	2 🗇 NO	OF DEATH?		
	DID TOBACCO USE CONTRIE				UNCERTAIN			1 TES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		OIACEKIAII					
Sic		IOSPITAL:		THER:	5 Residence	8 Other (Specify)				
ᇎ	27. MANNER OF DEATH	28e. OATE OF INJURY (Month, Day, Year)	28b, TIME C	F 28c. INJU	JRY AT	28d. DESCRIBE HOW	INJURY OCCU	RED		
BY	1 Niftural 5 Pending 2 Accident Investigation				ES 2 NO					
ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — A building, atc. (Specify)	t home, ferm, stre	et, factory, office		281. LOCATION (Street City or Town, State	end Number or	Rural Route Number,		
ETE										
COMPLET		N: To the best of my knowledge								
8	MEDICAL EXAMINER:	On the beele of examination end	d/or investigation, i	n my opinion, de	ath occured at the	time, data end place, o	and due to the o	ceuse(s) end menner ee stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER		>	-110	29c. LICENSE NUM	IBER	29d. OATE S	SIGNEO (Month, Day, Year)		
5	00. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CALLES OF THE	UYEN OZ Z	-MD	-5D	26231	1	5-15-40		
	OMES	A. AIOI	IF NI		365 N	CAAR S	T.	BATTO NO ZRA		
	31. DATE MAR 1 4 1995 A	32. HICHTINE SIGNATUR	E C							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

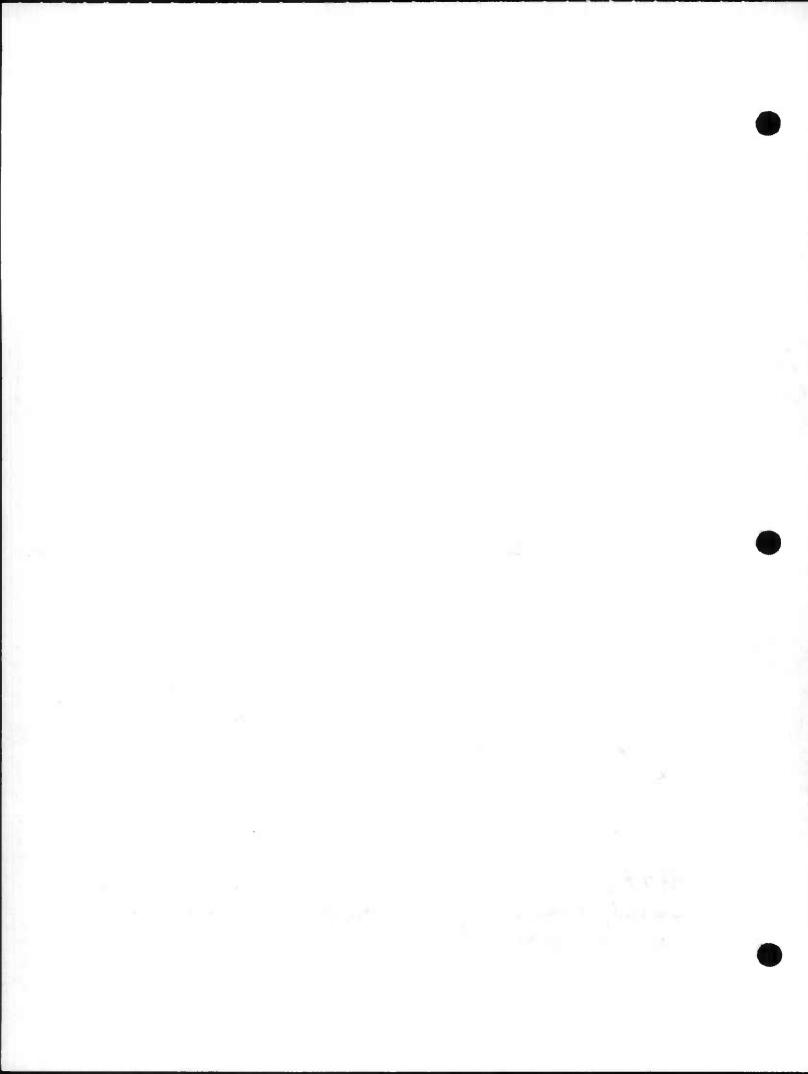
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

_	HEGISTRAH			EKIIF	ICALE	OF	DEATH		REG. NO.			
8	DECEDENT'S NAME (First, Middle, Last)	Hugo	Alberto	Ca	valler	,0		M	ATE OF DEATH DATE ON THE DATE OF DEATH DATE	. 19	YEAR 995	3. TIME OF DEATH 8:45 a. M
8	4. SOCIAL SECURITY NUMBER 105-38-4688	5. SEX 1 [X] M 2 [] F	6. AGE (In yrs. las	yrs.	IF UNDER 1 Y	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7.0	ATE OF BIRTH fonth, Day, Year) t 27, 19		6. BIRTN Country	PLACE (State or Foreign
R	98. FACILITY NAME (If not institution, give single of the			9b. CITY, TOWN OR LOCATION OF DEAT Baltimore			EATH	ATH 9c. COUNTY OF DEATH			EATH	
K	RESIDENCE OF DECEDENT		Dalolmore of of					14///				
FUNERAL DIRECTOR	Maryland 10b. COUNTY	N/A			Y, TOWN OR I		on altimor	e C				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
ERAL	100. STREET AND NUMBER 7018	Hamlet	Avenue			7 -	ZIP CODE	123		-		HAT COUNTRY? States
3	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13 WM	S DECE	MOENT OF HISDA	NIC OF	IGIN? (Specify Yes			
B	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 X	10	If ye	ea, spec	cify Cuban, Maxic	an, Pue	gentinia	- 1	Black Specif	, American Indian, White, atc.
	15. DECEDENT'S EDUC		16a, DE	CEDENT'S	USUAL OCCU	UPATION	M		16b. KIND OF BUS		USTRY	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4 or 5 +	(G.		vork done duri se retired.) SICIAN		t of working		Enter		0.00	
8	17. FATNER'S NAME (First, Middle, Last)					T	18 MOTHER'S NA	AME /E/	rst, Middle, Maiden	Currence)		
BE	19a. INFORMANT'S NAME (Type/Frint)	Alberto						Ad	a Podio			
2	Susana L. Cav	allero	191	701	8 Ham	let	Ave.	Bal	timore, N	n, State, Zip 1d .	2123	4
	20a. METHOD OF DISPOSITION 1	oval from State			of DISPOSITION (New Place)			1		WSON	City or Tov	aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	Miltor	JKnig		γ 22. NAI	ME AND	ADDRESS OF FA	ACILITY	Leonard	J.	Ruck	Inc.
	- Millon.	- Knip	V L V				Harford			., M	d. 21	1214
,	23. PART I. Enter the diseases, of control shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	at only one cau	se on aach lina		Cincom		e of dyling, auc	ch aa c	cardiec or reapi	ratory arr	est,	Approximate Interval Between Onset and Death
z		DUE TO,	OR AS A CONSEC	OUENCE OF	F):							
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST d											
	PART II. Other algnificant conditions	contributing to	death but not a	anultina i	h the color	et de c	and with a	D				
EDICAL	Tall II. Other agrillosis conditions	contributing to	oeath but not n	eauting	in the under	riying	cause given in	- Part I.	24a. WAS AN PERFORM	MED?		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S NC		UNCERTAI	N 🗵				1 □ YES 2 KNO
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT	N (Check only						1	
इं ॥	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	Nome	5 Residence		Wher (Specific)			
Y PHYSICIAN:	27. MANNER OF DEATN 1 Netural 5 Pending	28e. DATE OF (Month, De	INJURY	28b. T/M	E OF 280 URY	c. INJUI	RY AT	_	DESCRIBE NOW IN	JURY OCC	CURED	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28a. PLACE Of building,	F INJURY — At horate. (Specify)	me, farm, a	treel, factory,	office		261. LOCATION (Street and Number or Rural Route Number, City or Town, State)				oute Number,
Щ	29a, CERTIFIER											
COMPLETED	(Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE											and manner as stated.
S I	SHATURE AND TITLE OF CERTIFIER						29c. LICENSE NUI	MBER		29d, DATE	SIGNED /	Month, Day, Year)
0 8	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUC	E OF DEATH ATT	4 970 /T-	Dalam .		. 4 . 14	633	1	▶ 3	13	195
	G-Swittling 40 one	ology Conte	- Rm 126.	John	s Heplair	n Ite	sprtal 60	UN	welfest.	Buth	mae s	40
	MAR 1 4 1995	1 32 TESISTER	E REWARD	1								



BALTIMORE, MARYLAND 21215-0020	nted within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit, Pages 1, 2, 3 should rial, cremation, or removal.
Φ.	urs after	remova
3760	nted within 24 hou	completely filled in by the rial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HISPITAL OF ATTENDING THE ISSUED THE IAW requires that the death certificate be executed within 24 hours	TO THE FLACTAL DIRECTOR AND THE PARTY OF THE	be find within 72 from a property and property of Health and Mental Hygiene prior to burial, cremation, or re	The second secon

Ι	te	# 20c Film # G 721 3-1	14-95 N.A. Per	Funeral H	ome			95 0	7594
		FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF I		NTAL HYGIENE REG. NO.		
	No. 110st	100110	SON				MARCH 12	1945	3. TIME OF DEATH
		220-09-3671	□ M 2 □XF 9	yrs. lest birthday) 4 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN. A	DATE OF BIRTH (Month, Day, Year) April 27,19	00 Country	
	CTOR	98. FACILITY NAME (If not institution, give street Northwest Hospital RESIDENCE OF DECEDENT	· ·			OR LOCATION OF DEATH	9c.	Balti	
	DIREC	Md Balti	imore	2.5	y, town or Local				10d. INSIDE CITY LIMITS? 1 YES 2 NO
	FUNERAL	100. STREET AND NUMBER 615 Edmondson Aven	ıue		10	21 228	10g	CITIZEN OF WI	
	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, s	CENDENT OF HISPANIC Opecify Cuben, Maxican, Pt	PRIGIN? (Specify Yes or No Jarto Rican, etc.)	0- 14. RACE Black, Specify	
	PLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) 1.2		(Give kind of the Do NOT us	USUAL OCCUPATION or retired.)		166. KINO OF BUSINES		white
100	BE COMPL	17. FATHER'S NAME (First, Middle, Lest) Samuel Appel			4160		First, Middle, Malden Suma Younger		
e notifie	2	19a. INFORMANT'S NAME (Type/Print) Doris Harris				and Number or Rural Route on Avenue,			21228
		20e. METHOD OF DISPOSITION 1	I from State cemet	erv. crematory or o	of disposition (Nather place) Ct Cemet		DATE 20c. LOCATIO Baltimo 3/15 Freder	ne city or Town	n, Stata
examiner		21. SIGNATURE OF FUNERAL SERVICE LICENS	Hacks		Sterl	ing Ashton	Funeral Ho	ome	e. Md.21228
event, the medical		23. PART I. Enter the diseases, or comshock, or heart fellure. Lief IMMEDIATE CAUSE (Finel disease or condition resulting in death)	polications that caused it only one cause on each of the cause on each of the cause on each of the cause of t	ch line.	not enter the mo	ode of dying, such as	cardiec or respirator	y errest,	Approximate interval Between Onset and Desth
5	CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A C						
hows any inju	MEDICAL	PART II. Other eignificant conditions of the following of	9				PERFORMED?	6	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
EZ	SICIAN	25. WAS CASE REFERRED DO MEDICAL EXAMINER?		L PLACE OF DEA	H (Check only one) OTHER:				
		27. MANNES OF DEATH 1 Metural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	JURY AT 26d	I. DESCRIBE HOW INJURY	OCCURED	
	1	3 Sulcida 6 Could not be	28e. PLACE OF INJURY — building, atc. (Specify	At home, ferm,	street, fectory, offic	281	LOCATION (Street and Nu City or Town, State)	imber or Rural Ro	oute Number,
IMPORTANT: If them 24	OMPLE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C	N: To the best of my knowled On the basis of examination a						and manner ee stated.
IMPORTA	ŭ,	30. NAME AND ADDRESS OF PERSON WHO CO	A SA	M OTEM OT C	Polati	29c, LICENSE NUMBER	72 >	DATE SIGNED	15 1995
'		HAROLD By 31. DATE FILED (Month, Day, Year)	B B 7	220	PARK	High	E Arr	712	es s

BUB 7270

32 AEGISTRAP'S SIGNATURE

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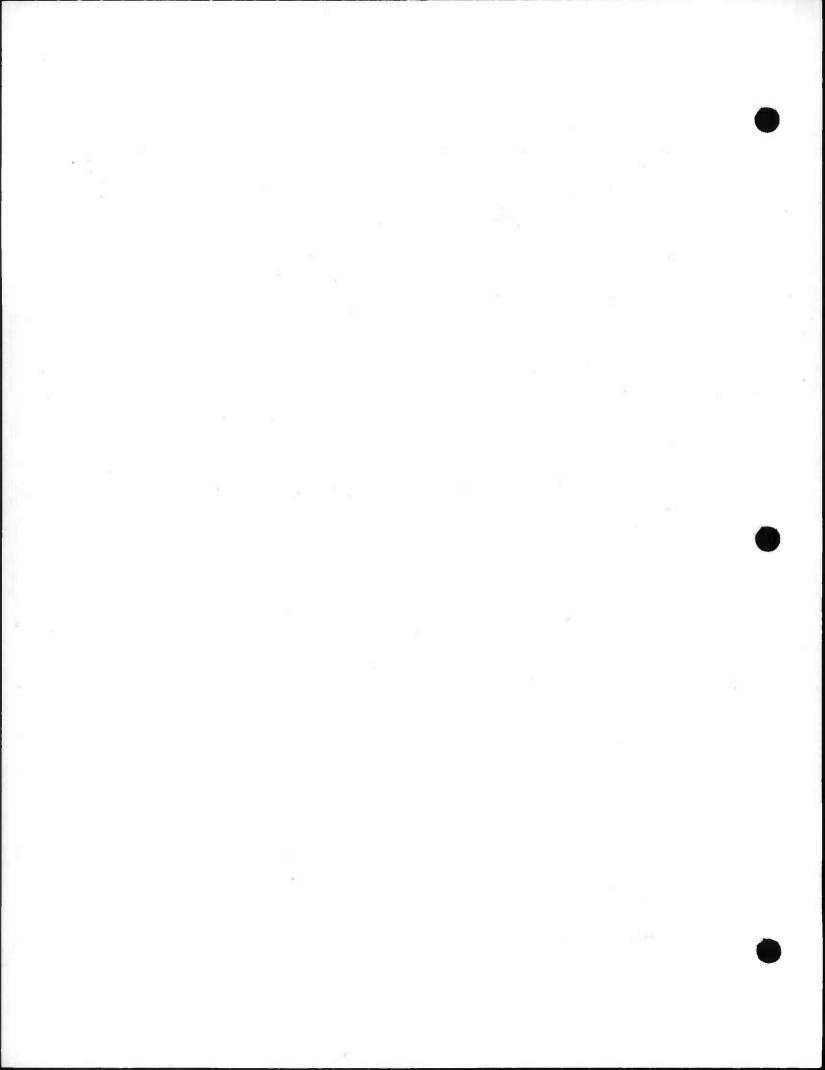
31. DATE FILED (Month, Day, Year) 4.1995

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

		1. DECEDENT'S NAME (First, Middle, Last)	OLITIII	TORIE OF DEATH	REG. NO.				
			TER		2. DATE OF DEATH MONTH DA NARCH	V YEAR 7 15 AM			
)	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. last birthday)		RS. 7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign			
à		213-52-3072 1× M201	45 YRS.	MONTHS DAYS HOURS M	N. American (Month, pay, Year)	49 MARIAND			
3 should	l oc	9a. FACILITY NAME (If not institution, give street and number)	110	96. CITY, TOWN OR LOCATION O	F DEATH	9c. COUNTY OF DEATH			
1, 2, 3	Ĕ	RESIDENCE OF DECEDENT	1/ LEN/ER	MALTIMO	风5_	N/A			
Pages	DIRECTOR	10a. STATE 10b. COUNTY	10c. Cf	TY, TOWN OR LOCATION		10d. INSIDE CITY JJMITS?			
permit. P		100. STREET AND NUMBER		DALIMORE_		1 X YES 2 NO			
. ist	FUNERAL	2308 NEVADA STI		10f. ZIP CODE 2123	30	10g. CITIZEN OF WHAT COUNTRY?			
215-0020 attending physician. se as the burial-transit	J.	1 Never Married 2 Married FORCES?	ENT EVER IN U.S. ARMED	If yes, specify, Cuban, M	SPANIC ORIGIN? (Specify Yes exican, Puerto Rican, etc.)	or No.— 14. RACE — American Indian, Black, White, atc.			
21215-0020 al or attending physic for use as the burial	B	3 Wildowed 4 Divorced IF YES, GIVE	WAR OR DATES		pecify:	BLACK			
r attend use as	I	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of	S USUAL OCCUPATION work done during most of working	16b. KIND OF BUS	INESS/INDUSTRY			
AND 21 the hospital or detached for u	APLET	Elementary/Secondary (0-12) College (1-4 or		ack HOTEL					
LAN the ho	COMPL	17 FATHER'S NAME (First, Middle, hast)		18. MOTHER'S	NAME (First, Middle, Meiden	Sumame)			
tained by should be	Б Ш	TAYTII (ON AR BR	1	EL	A YOUNG	7			
5 cm 5		198. INFORMANT'S NAME (Type/Rylnt) PRENDA DINGLE	19b. MAILING 230	ADDRESS (Street and Number or R	ural Route Number, City or Town	n, State, Zip Code)			
may be		201 METHOD OF DISPOSITION 1 Burtel 2 Crematign 3 Removal from State	200. PLACE AND DATE	OF DISPOSITION / Manne of	DATE 200 LOC	CATION — City or Yours, State			
MOR age 6 ma director, p		4 🗆 Donation 5 🗆 Other (Specify)	17777	TON CEM,	3/14/95 Lar	Staura MV.			
BALTIN Ber death. Pag the funeral di mal.		21. SIGNATURE OF FUNDRAL SERVICE LICENSEE		22. MANE AND ADDRESS O	12 PCH FEND	RALHOME TA,			
after death. Page by the funeral dire moval.		X fort / // fort		270 FRED	HITTON PAS	5 BATIMO, 21299			
hours after ed in by th or remove		23. PART I. Enter the diseases, or complications to shook, or heart fallure. List only one of	at caused the death. Do suse on each line.	not enter the mode of dying,	such as cardiac or respir	atory arrest, Approximate interval Between			
y fille		IMMEDIATE OAUSE (Final disease or condition	NG CAN	ICER		Onset and Death			
omplete			O (OR AS A CONSEQUENCE O						
		Sequentially list conditions, b.							
OX 68 e be execut sician and c nior to buris traumatic	CATION	if any, laeding to immediate cause. Enter UNDERLYING	O (OR AS A CONSEQUENCE O	F):					
certificate ding physi lygiene pr		CAUSE (Disease or injury that initiated events	O (OR AS A CONSEQUENCE O	P):					
J = 5 = 5	5 15	resulting in death) LAST							
		PART II. Other significant conditions contributing	o death but not resulting	In the underlying cause giver					
E # 6 # 9	2	RETROVIER DI			PERFORM	MED? AVAILABLE PRIOR TO			
Heal Sign	2 ≥			_		OF DEATH?			
Law law		DID TOBACCO USE CONTRIBUTE TO C			AIN 🗆				
SICIAN: The certificate h the State Ed. or Hem		EXAMINER? HOSPITAL:	26. PLACE OF OEA	TH (Check only one) OTHER:	• • • • • • • • • • • • • • • • • • • •				
HYSICIA his certif with the	≥	27. MANNER OF DEATH 28a. DATE (Month)	F INJURY 28b. TIN		28d. DEŞCRIBE HOW IN	JURY OCCURED			
DING PHYS After this of death with	ВУ Б	1 Netural 5 Pending 2 Accident Investigation		M 1 YES 2 NO					
TTENDI TTOR: A affer d	밀	3 Suicide 28e. PLACE	OF INJURY — At home, tarm, p, atc. (Specify)	street, factory, offica	281, LOCATION (Street ar City or Town, State)	nd Number or Rural Route Number,			
R S S S S S S S S S S S S S S S S S S S	- 4	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best	of my knowledge, death occurr	ed at the time, data and place, and	due to the causa(s) and mann	ner as stated.			
TO THE HOSPITAL (TO THE FUNERAL B Be filed within 72 h IMPORTANT: If III	COM					I due to the cause(a) and manner as stated.			
HE HO HE FUI ed with	E C	296 SIGNATURE AND TITLE OF CENTIFIE		29c. LICENSE	NUMBER	29d. DATE SIGNED (Month, Day, Year)			
5 5 5 W	TO B	1 mm V J ma	1	35/10	2318	3/10/95			
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CA	OF OEATH (ITEM 27) (Type	MOUPE S	- 0-	MAD DISON			
3		31. OATE FILED (Month, Day, Year) 32. REGISTI	AR'S SIGNATURE	V.100-2 S	187.171	40EE MD 21287			
		MAR 1 4 1995 Alication	dear Randall						

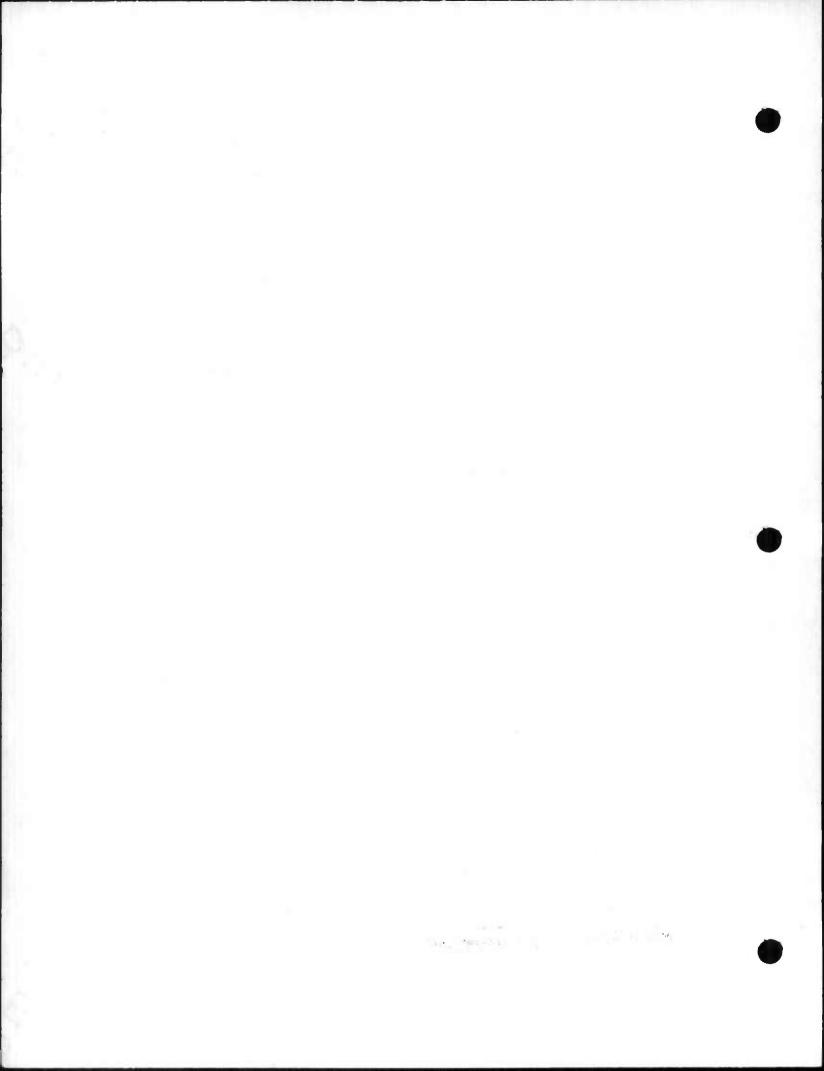


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 hours after death with the State Dent of Health and Marrat Husines notes to bring the managing or removed. DIVISION OF VITAL RECORDS, P.O. B

	REGISTRAR		CERTIFIC	AIE OF	DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	1	0	-00		2. DATE OF DEATH		3. TIME OF DEATH		
	(-INDA 1	n. ChA	MRA	7		MARCH	111100 C	-12 12 A		
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs.	fact birthday .	UNDER 1 YEAR			1111773	10.30.1		
		M 2 [4 /	100	NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Count	HPLACE (State or Foreign fry)		
	L Z 1 Z = 30 = 8U33		YRS.			April 23,1	953	MD		
11	9a. FACILITY NAME (If not institution, give street	and number)	9	. CITY, TOWN	OR LOCATION OF DE			9c. COUNTY OF DEATH		
DIRECTOR	Harbor Hospital Cen	ter		3altimo	200					
1 8	RESIDENCE OF DECEDENT	1001		Jartini	JI E			<u> </u>		
ŭ	10a. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCA	TION			10d. INSIDE CITY		
1 5	MD		D-1+	•				LIMITS?		
	10e. STREET AND NUMBER		Bait	imore				1 YES 2 NO		
RAL				10	f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
<u> </u>	1523 Hazel Street			1 2	21226		US	A		
FUNE	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U.S.	ARMED			IC ORIGIN? (Specify Yes		E - American Indian,		
	1 Never Married 2 Married	FORCES? 1 YES 2 FYES, GIVE WAR OR DATES	ОиО	If yes, sp	ecify Cuban, Mexical	n, Puerto Rican, etc.)	Blac	k, White, etc.		
B	3 Wildowed 4 Divorced	IF TES, GIVE WAR ON DATES		1 U YES	2 NO Specify		Spec			
	15. DECEDENT'S EDUCATION	N	250-25-1-10					White		
ETE	(Specify only highest grade comp	oleted)	(Give kind of world	done during me	ON ost of working	16b. KIND OF BUS	INESS/INDUSTRY			
"	4.6	offege (1-4 or 5 +)	ille. Do NOT use n							
ਜ਼ ਉ	10		Jtility	Worker	1	Baltimo	re City	Government		
at once.	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden S		TO THIO IT		
111 m	John Ed Laster				A CONTRACTOR OF THE PARTY OF TH		,			
led a	19s. INFORMANT'S NAME (Type/Print)		10h W.1	Opena in	KULII E	<u>stelle Wal</u>	ker			
TO BE						Noute Number, City or Town				
De n	Sherry Terry		<u>1319 S</u> ,	Carey	Street	Baltimore,	MD 212	30		
2	20a. METHOD OF DISPOSITION	20b. PLAC	EANDDATEOF	ISPOSITION (N	ime of		ATION - City or To	7.7		
must	1 Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	rom State cemetery, of	crematory or other	place)	Inc	2/12 0-1	+ imau	MD		
6	21. SIGNATURE OF FUNERAL SERVICE LIGHTS	A TIME CI	O CI CIIIC	LOTY	NO ADDRESS OF FAC	3/13 Bal	timore,	MU		
examiner	Carried Land	Tel VIST	_	McCul	Tv Funer	al Home of	Brookly	n 21225		
S S	Steven	H. Williams		237 F	Datanc	co Avenue,	Dr Johns	II LILLY		
20	23. PART I. Enter the diseases, or comp		don'th Do and	237	. rataps	co Avenue,	Daitimo			
medical	shock, or heart failure. List	Only one cause on each li	ne.	enter the mo	de or dying, sucr	as cardiec or respir	ratory arrest,	Approximate interval Between		
	IMMEDIATE CAUSE (Final	2	. 0					Onset and Death		
£	disease or condition	IUEUMONI	A S	PSIS	A	NEMIA	No.	15 DUL :		
T .	resulting in death)	DUE TO (OR AS A CONS	SEQUENCE OF:			1,000		1010		
other traumatic event, the TIFICATION		PER DO	RE	CVALL	Donne			71		
ry, or other traumatic	Sequentially list conditions, b	DUE TO (OR AS A CONS	1682	24101	PRUMIC			S /day		
5 F	if any, leading to immediate	AZUT - D-	SECUENCE OF):	a.		11/117/5	DILLIG			
5 3	CAUSE (Disease or Injury	NOU LE RE	NAL	FATT	CURE	MULTIO	KGANLY	4/4		
흥분	that initiated events	DUE TO (OR AS A CONS	EOUENCE OF):		4	. /		7		
P E	resulting in death) LAST	ALCONOUC	HET	ATITI	SWITH	HIGHER	ATITIC	C 3rRC		
						-10	,,,,,,	9		
rs any injury, EDICAL CI	PART II. Other aignificent conditions co	ntributing to deeth but not	t resulting in t	he underlying	g ceuse given in l	Part I. 24s. WAS AN		WERE AUTOPSY FINDINGS		
≥ 2						PERFORI		AVAILABLE PRIOR TO COMPLETION DF CAUSE		
20 111						1 TES 2	NO	DF DEATH?		
Ž Z						7		1 TES 2 NO		
AN: R	DID TOBACCO USE CONTRIBU	JTE TO CAUSE OF DE	ATH YES	□ NO □	UNCERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		ACE OF DEATH (Check only one)						
Item SICI/		SPITAL:		THER:						
5 ×	27. MANNER OF DEATH	28a. DATE OF INJURY			e 5 🗆 Rasidence (
is marked, D BY PH	1 Pending	(Month, Day, Year)	28b. TIME O		RK?	26d. DEŞCRIBE HOW IN	JURY OCCURED			
mari BY	2 Accident Investigation			M 1 🗆 1	rES 2 NO					
= 0	3 Suicide 6 Could not be	28a. PLACE OF INJURY - At I	home, farm, stree	t, factory, offic		281. LOCATION (Street ar	nd Number or Rural F	Route Number,		
2 E	4 Homicide determined	building, atc. (Specify)				City or Town, State)		COLUMN TO THE PARTY OF THE PART		
Item 2	29a. CERTIFIER									
= 4	(Check only Check only	To the best of my knowledge,								
ANT: If the	2 MEDICAL EXAMINER: On	the besis of examination and/o	or investigation, is	n my opinion, d	eath occured at the t	lime, date and place, and	dua to the cause(s) and manner ee stated,		
	29b. SIGNATURE AND TITLE OF CERTIFIER		1		29c. LICENSE NUM	RER	204 DATE CIONES	Month Dec Wood		
S H	Jarty Shop	Three	1		AT OLL	11/11/20	29d. DATE SIGNED	(Morith, Day, Year)		
፮ ይ	N-0.1	2101610			112 24	11614 36	PIVIF	11,1475		
-	30. NAME AND ADDRESS OF PERSON WHO COM	MPLETED CAUSE OF DEATH (IT	EM 27) (Type, Prin	ot)						
	IVAUTE SINGH	BUTTAR	3001	Sth	HALLOV	ER ST.	BAITI	MOREMD		
	31. DATE EILED (Month, Day, Year)	-32. REGISTRAR'S SIGNATURE		,	1. 55		B.101	101011		
	MAK 1 4 1995 (1)	Mist o .								
	iooo jiaa	THE PERSON NAMED IN								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. DATE FILED Month, Day, Year)
MAR 1 4 1995

3 should

	L.R.B.										9) U	1391
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR	RTMENT	OF H	EALTH DEAT	AND I	MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)									E OF DEATH			. TIME OF DEATH
	SEAN	MIC	HAEL			ONRO	YC		MAF	RCH 12	1995	YEAR	1:10A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER		IF UNDER		7. DAT	E OF BIRTH		8. BIRTHPI	ACE (State or Foreign
	212 90 8158	1 X M 2 D F	2.7	YRS.	MONTHS	DAYS	HOURS	MIN.		nth, Day, Year) PC 27	196	Country)	a
	9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY	, TOWN C	R LOCATIO	ON OF DE		ec 2/		JNTY OF DEA	
S S	UNIVERSITY HOSPIT	TAL S.T.U			BAT	TIMO	ORE C	TTY.					
ᇈ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT							7111					
DIRECTOR	7.0			10c. CITY, TOWN OR LOCATION							. 1	0d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	e Arunde	5.1	L A	nna								XX ES 2 NO
FUNERAL		-				101	. ZIP CODE				10g. CIT	IZEN OF WH	AT COUNTRY?
R	583 Pinewood	7					214					US	A
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 N	MED IO		f yes, spi		n, Mexica	n, Puert	ilN? (Specify Yes o Rican, atc.)	or No—	14. RACE - Black, V Specify: Whit	- American Indian, White, etc.
E	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON .		110	Sb. KIND OF BUS	SINESS/INI		
Ш	Elementary/Secondary (0-12)	Coffege (1-4 or 5 +) life.	Do NOT us	se retired.)	aunng mo	st of workin	g					
COMPLETED	12	4	At	tor	ney					Law			
00	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NA	ME (First	, Middle, Maiden	Surname)		
BE	Richard L. C	onroy						-		roll			
19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)													
	Richard L. Co	nroy		83	Pine	ewoc	od D	r.,	An	napol	is,	Md 2	1401
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem	oval from State	20b. PLACE A cemetery, crer			ITION (Na	me of		DA	lact !		City or Town	
	4 Donetion 6 Other (Specify)	CENTEE	/ Wake	mon	tice	met	D ADDRES		3/	7 Da	vids	onvi	lle Md
	· Date of	april	1/2		I P	lard	dest	y F	une	ral He	olie	L M	, 12 21401
	23. PART I. Enter the diseases, or ahock, or hear failure.	complications that	caused the dea	th. Do r	ot enter	the mo	de of dyi	ng, auci	98 C8	rdiac or reapi	ratory ar	reat,	Approximate
	iMMEDIATE CAUSE (Fine)	A A	se on each line	\									interval Between Onset and Daath
	disease or condition resulting in death)	. IVIM	1100	p	In		a						
	rooming in dominy	DOE 10	OH AS A GONSEO	WENCE OF	9		~						
Z		b	,										
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEO	UENCE OF	F):								
2	CAUSE (Disease or injury	c											
	thet initieted events resulting in death) LAST	DUE TO (OR AS A CONSEO	UENCE OF	F):								
5		d											
١	PART if. Other aignificant condition	a contributing to	deeth but not re	suiting i	n the un	derlying	ceuse g	iven in	Part I.	24e. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
MEDICAL										PERFOR			MILABLE PRIOR TO OMPLETION OF CAUSE
									_	1 YES 2	□ NO		F DEATH?
-	DID TOBACCO USE CONT	RIBUTE TO CAI	USE OF DEAT	TH YE	SIL	ио П	LINC	ERTAIN				,	YES 2 🗆 NO
A	25. WAS CASE REFERRED TO MEDICAL			_	H (Check		OITC	LKIZII					
Sic	EXAMINER? 1 VES 2 NO	HOSPITAL:	ER/Outpatient 3	DOA	OTHER 4 Num		5 Dec	aldonno	s 🗆 🗪	ner (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF	INJURY	26b. TIM	E OF	28c. INJU	JRY AT	The state of the s		ESCRIBE HOW II	JURY OC	CURED	11 -
	1 Netural 5 Pending	(Month, Da	12.45	OP	5M	1 Y		NO		UPANT	IN	AUTO	MITO
Э ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	INJURY — At hon		_	ory, office			26f. LO	CATION (Street a	and Number	or Rural Rou	te Number,
TED	4 Homicide determined	ounding, a	rtc. (Specify)	51	00	ET	100	1 4	Rus	y or Town, Stete)	IMAD		Es. BALTO
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of a	my knowledge de-	th occurr	ed ad the d	ma destr	and alone	and stor	1000	-00	11120		0.8.3-10
M		R On the bests of ex											nd manner on street
	296. SIGNATURE AND TITLE OF CERTIFIES									1			
BE	/has	X2					29c. LICE						onth, Day, Year)
2	36. HAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH (ITEM	27) (Type.	Print)		0.0	C.M.	<u>.</u>		MA	KCH I	2, 1995

111 PENN STREET, BALTIMORE, MARYLAND 21201.

Richard L. Conroy

583 Pinewood Dr., Annapolis, Md 21401

3//f Davidsonville Md Wakemont Cemetery

Hardesty Funeral Home, P.A., 12 RIdgely Ave., Annapolis, Md 21401

DIVISION OF VITAL RECORDS, P.O. BOX 68760

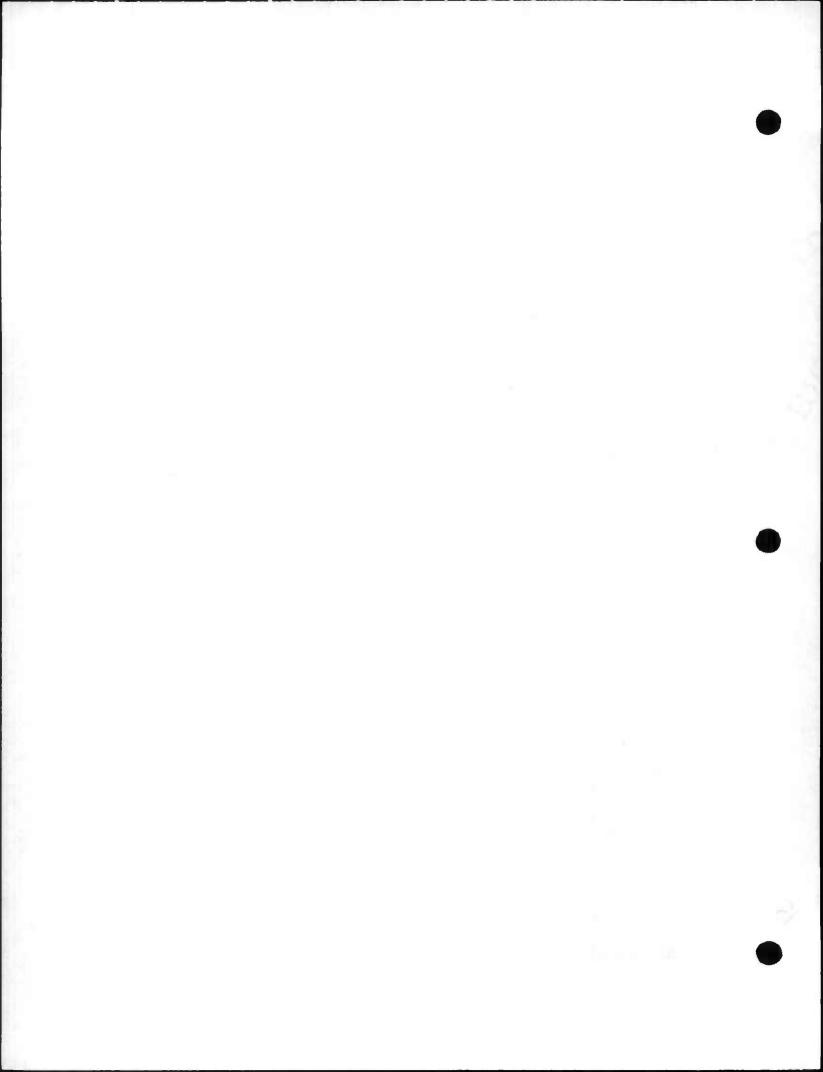
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow of the death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

-	REGISTRAN		-	ENTIF	ICALE	UF	DEATI	П	REG. N	Ο.						
8	1. DECEDENT'S NAME (First, Middle, Last) FRANCIS WA	RD	DeGRA	NGE,	SR.				2. DATE OF DEATH	8°, 1	995	3. TIME OF DEATH 5:00 A				
8	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs.	last birthday)	IF UNDER		IF UNDER 24	HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign				
	212-07-5147	1 🔀 M 2 🗆 F	79	YRS.	MONTHS	ONTHE DAYS HOURS MIN. 10-16-1915 MARYLAN					YLAND					
œ	9a. FACILITY NAME (If not institution, give street and number) 4 KUETHE ROAD					96. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE ANNE ARUNDI										
DIRECTOR	RESIDENCE OF DECEDENT			000	N DO.	TAT			ANNO	ARONDEL						
1	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O							10d. INSIDE CITY LIMITS?				
	MARYLAND AN	NE ARUN	IDEL		G L E		URNI	E .		_		1 TYES X NO				
FUNERAL	4 KUETHE ROAD					101. ZIP CODE 109. CITIZEN C					U.S					
<u>N</u>	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	T EVER IN U.S.	ARMED	13. W	WAS DEC	ENDENT OF	HISPANI	C ORIGIN? (Specify)	ea or No-	14. RACE	— American Indian, , White, atc.				
B⊀	1 Never Married 2 Married 3 Wildowed 4 Divorced	Лио			icity Cuban, X□ NO		, Puarto Rican, etc.)			WHITE						
Ë	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)		DECEDENT'S	vork done di	CUPATIO	N st of working		16b. KIND OF B	USINESS/IN	DUSTRY					
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 + N/A)	ESIDI		retired.)					R CO.					
BE CO	17. FATHER'S NAME (First, Middle, Last) JOHN A. DeGF	RANGE				18. MOTHER'S NAME (First, Middle, Malden Surneme) LAURA WICKLESS					SS					
2	19a. INFORMANT'S NAME (Type/Print) JOHN E. DEGRAM	NGE, SR.			ING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 SHAWNEE COURT, MILLERSVILLE, MD.21						MD.21108					
	20s. METHOD OF DISPOSITION 1 XBurtal 2 ☐ Cremation 3 ☐ Rame 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemetary, c	E AND DATE (crematory or of	her place)		3		195		- City or To	.,				
- 1	21. SIGNATURE OF FUNDMAL SERVICE LA	ENSEE	IGLEN	<u>HÁVI</u>	22. N	IAME AN	RIAL D ADDRESS	OF FAC	WING T NGLE	TON B	BUNE	E, MD. RAL HOME,				
	1 1 1 No.	etter			1	SEC	OND	AVE	NUE, S.	W.		Kild Holle,				
	23. PART i. Enter the diseases, or o shock, or heart fallure.	complications that List only one cau	ceused that	death. Do n	ot enter t	the mo	da of dying	, auch	as cerdiec or ree	piratory si	rrest,	Approximate Interval Between				
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	Longs	hosa	rein	ve	0	m	en	Terrie 1	enl	2-	Onset and Death				
	DU TO (OR AS A CONSEQUENCE OF):															
NOI	Sequentisity list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):															
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	c														
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONS	EOUENCE OF):											
S		d														
Ä	PART II. Other algnificent condition	a contributing to	death but not	t recuiting	n the und	deriying	ceuse giv	en in P	ert I. 24s. WAS A	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
EDICAL		Gust	wat		11	77	6	m	YES	2 🗌 NO		OF DEATH?				
PHYSICIAN: M	DID TOBACCO USE CONTE	RIBUTE TO CAL	USF OF DE	ATH YF	SΠN	10 D	UNCE	DTAIN				1 TES 2 NO				
Š	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ACE OF DEAT	H (Check or	nly one)	OTTOL	XIZ.II X								
YSI	1 TYES 2 NO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER:		5 A Rosk	denca 6	Other (Specify)							
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, Da		28b. TIMI INJ		28c. INJU WOI	HK?	_	28d. DESCRIBE HOW	INJURY OC	CURED					
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	F INJURY — At I	home, farm, s	treet, factor		E3 2		261. LOCATION (Stree	and Numbe	r or Rural Ri	oute Number,				
							261. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
	4 Homicide determined								29e. CERTIFIER (Check only one) 29m. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29m. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.							
MPLETE	29a. CERTIFIER (Check only															
COMPLETED	29a. CERTIFIER (Check only	R: On the beels of ax					ath occured	at the ti	me, data and place,	nd due to t	he cause(a)	- 1993				
H .	29a. CERTIFIER 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINE	R: On the beels of ax						at the ti	me, data and place,	nd due to t	he cause(a)	and manner as stated. (Month, Day, Year)				
H .	29a. CERTIFIER 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINE	R: On the beels of ex	amination and/o	or investigation	n, In my op		29c. LICENS	at the ti	me, data and place, a	29d. DAT	TE SIGNED	(Month, Day, Year)				
TO BE COMPLETE	29a. CERTIFIER 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINET 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHITE	R: On the basis of ax	emination and/o	or investigation	n, In my op		29c. LICENS	at the ti	me, data and place, a	29d. DAT	TE SIGNED	- 1994				
H .	290. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CERTIFIER	R: On the basis of ax	PME OF DEATH (IT	or investigation	n, In my op		29c. LICENS	at the ti	me, data and place, a	29d. DAT	TE SIGNED	(Month, Day, Year)				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be esecuted within 75 hours after death. Page 5 may be retained by the historian physician and completely filled in by the functor, page 5 should be detached by use as the burist-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to barist, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other transmittle event, the medical examples must be notified at once.

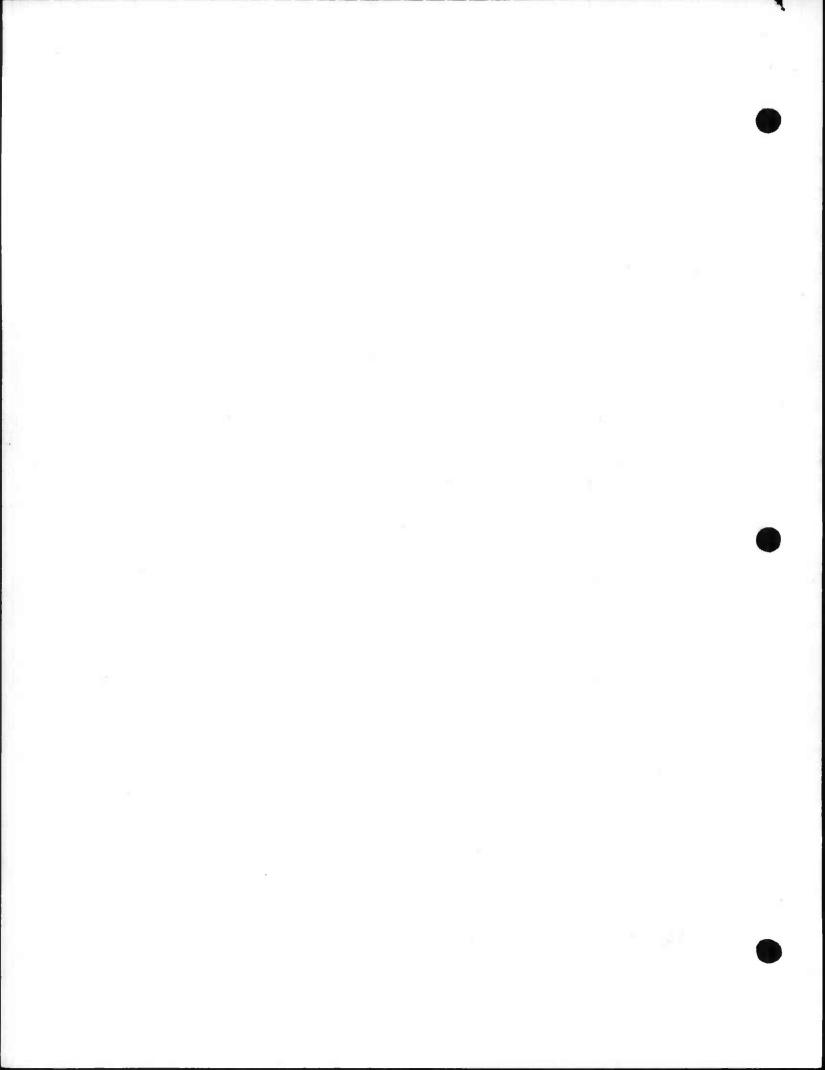
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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGII				
		FMAN				2. DATE OF DEATH	75	TEAN 3	TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 053-14-4896 Ba. FACILITY NAME (V not institution, give a	1 XX M 2 □ F	(In you lest birthday) 78 vas.	IF UNDER 1 YEARS	F UNDER 34 HRS. HOUNE MIN.	SEPT. 3, 1	916	NEW YO	WANTED TO THE PARTY OF THE PART	
DIRECTOR	LORIEN NURSING HOME	LORIEN NURSING HOME				EATH	Sc. COUNTY	D		
	MARYLAND B	ALTIMORE	10c. CIT		ALTIMORE			11	H. HISIDE CITY LIMITS? YES 2 XX HO	
FUNERAL	4112 ESSEX ROAD	IN U.S, ARMED	2	1207	NIC ORIGIN? (Specify	USA		American Indian.		
BY	1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 1 YES	2/1/ NO	If yee, so	ectly Cuben, Mexic 2 XXNO Speci	an, Puerto Rican, etc.)	14	Black, W Specify:	WHITE	
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12) 1.2 2	completed) College (1-4 or 5 +)	Ma. DECEDENT'S /Give Aind of /Ma. Do NOT us ENTREPR		ON sat of working	0.000	RIAL WAX		М	
BE COM	17. FATHER'S NAME (First, Middle, Lest) WILLIAM DORFMAN				18. MCTHER'S NAME (First, Middle, Malden Surrame) JENNY GLASSGOLD					
10	NORMA DORFMAN					Flower MARYLAND	100 21207	dej		
	20a. METHOD OF DISPOSITION 1 □ Burisl 2 X X Cremation 3 □ Rem 4 □ Donation 5 □ Other (SSKS) 21. SIGNATURE OF FUNERAL SERVICE Lec	ther place) (SHINGTON	CORRUN.	3/14 LAL	JREL, MAR	and the same	State			
	· Lalala	Silak	ay	760	1 SANDY SP	FLECK RING ROAD, I		ARYLA		
	22. PART I, Enter the diseases, oreshock, or heart fellure, in immediate Cause (Final disease or condition resulting in death)	. pnen	ONIO	n n	de of dying, suc	th as cardiac or res	spiratory arresi		Approximate Interval Between Onset and Death	
IFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	A CONSEQUENCE OF	7):						
CERTIFIC	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF	r]:						
PHYSICIAN: MEDICAL C	PART II. Other significant condition	s contributing to death to	but not resulting	in the underlying	g cause given in	PERF	AN AUTOPSY ORMED?	COL	RE AUTOPSY FINDINGS ANILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
IAN:	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	26. PLACE OF DEAT	S NO [UNCERTAI	N 🗆				
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outs		OTHER:	e 5 🗆 Residence	6 Other (Specify)				
ву Рн	27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation	Natural 5 Pending (Month, Day, Year) If				28d. DESCRIBE HOV				
ETED	3 Suicide 8 Could not be determined	street, factory, offic	, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLET	one) 2 MEDICAL EXAMINE	CIAN: To the best of my know R: On the besis of examination						euse(a) an	d manner as stated.	
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DEATH (ITEM 27) (Type, Print)

MAR 1 4 1995

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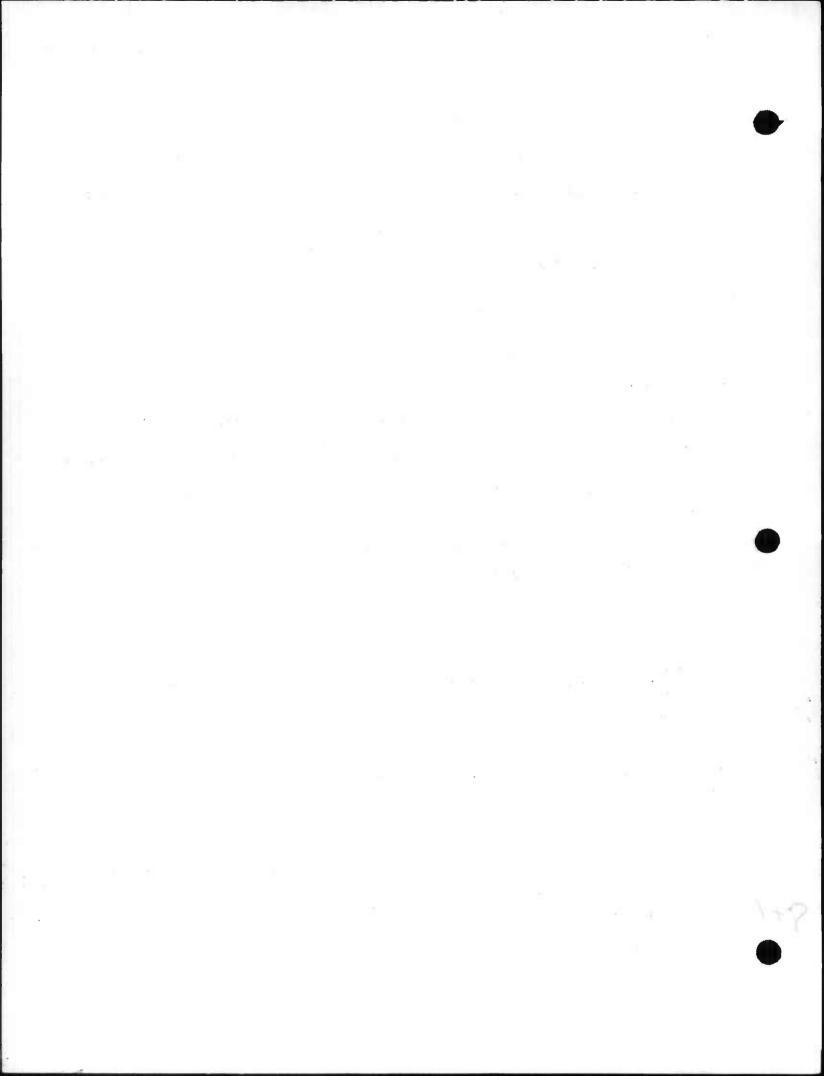


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		Pages
BALTIMORE, MARYLAND 21215-0020	recuted within mours after death. Page 6 may be retained by the hospital or attending physician.	and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within character death. Page 6 may be retained by the hosp TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the North Company of the company of the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MAR	IYLAND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Mil	Ph. F.DE	7.	, Sr.			3 th 199	5 10:35AM	
	4. SOCIAL SECURITY NUMBER 532-18-8958	1	AGE (In yrs. last birtnday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		l919 [∞]	RTHPLACE (State or Foreign ountry) Washington	
TOR	Meridian Nur	9e. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home RESIDENCE OF DECEDENT				EATH	9c. COUNTY OF GEATH Baltimore		
DIRECTOR	200	ob.county Baltimore		tonsvil			-	10d. INSIGE CITY LIMITS? 1 YES 2 NO	
FUNERAL	401 Dorchest	101	21228		10g. CITIZEN OF WHAT COUNTRY?				
BY	11. MARITAL STATUS 1 Never Merried 2 Mai 3 Widowed 4 Olvorce	IF YES GIVE WAR (ER IN U.S. ARMEO YES 2 NO OR DATES	If yea, sp	ENOENT OF HISPAI ecity Cuben, Maxica 2 NO Specif	IIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	8	ACE — American Indian, lack, Whita, atc. pecify: White	
COMPLETED	(Specify only hig Elementary/Secondary (0-12)	ENT'S EDUCATION ghest grade completed)) College (1-4 or 5 +) 4+	life. Do NOT us	vork done during mo e retired.)	ON st of working	16b. KIND OF BUS	INESS/INDUSTR		
BE COMF	12 17. FATHER'S NAME (First, Middle Michael Deig	<u>Teac</u>	her	18. MOTHER'S NA	ME (First, Middle, Maiden S	ore Con	unty		
5 8	19a. INFORMANT'S NAME (Type/ Patrick Deigr	nan	1			Poute Number, City or Town Catonsvill			
	20a. METHOD OF DISPOSITION 1 XBurlel 2 Cremation 4 Donation 5 Other (Sp.	3 🗆 Ramoval from State	20b. PLACE AND DATE Cometery, cremetory or of Meadowrid	her plece) ge		3/17 Ba1	timore	1501	
	> Huller	Alacha assa, or complications that can		Sterli 736 Ed	mondson	n Funeral	1to Mo	1. 21228	
PHYSICIAN: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant of the cause of the	a. DUE TO (OR DUE TO (OR OUE TO (OR C. DUE TO (OR	AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF	nal 7 esal i: n the undarlying Children 28. PL OTHER: 4X Nursing Hom	failure failure grause given in	Part I. 24a. WAS AN A PERFORM 1 YES 2 ack only one) 8 Other (Specify)	MUTOPSY MEO?	Approximate Interval Batween Onset and Daath 5 Ave. 4 Ave.	
ED BY	3 Suicide 8 Cou	estigation	URY — At home, ferm, a	M 1 U	RK? 'ES 2 NO	281. LOCATION (Street ar City or Town, State)			
COMPLET		ING PHYSICIAN: To the best of my k						ee(a) and manner as stated.	
TO BE	296. SIGNATURE AND TITLE OF	loug!			D · 3	269	> Mai	IED (Month, Day, Year) 13 15 19 95	
		ERSON WHO COMPLETED CAUSE OF		VR CLE	ELLI	to Truin		0.21042	
	MAR 1 4 1995	July d'audior de	irdall						



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DALI INODE, MANTEAND ZIZIS-UUZ	attending
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בב	hospital
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	Page
1	death.
3	after
_	hours
	recuted within thours after death. Page 6 may be retained by the hospital or attending I
	ecuted

DIVISION OF VITAL RECORDS, P.O. BOX 68760

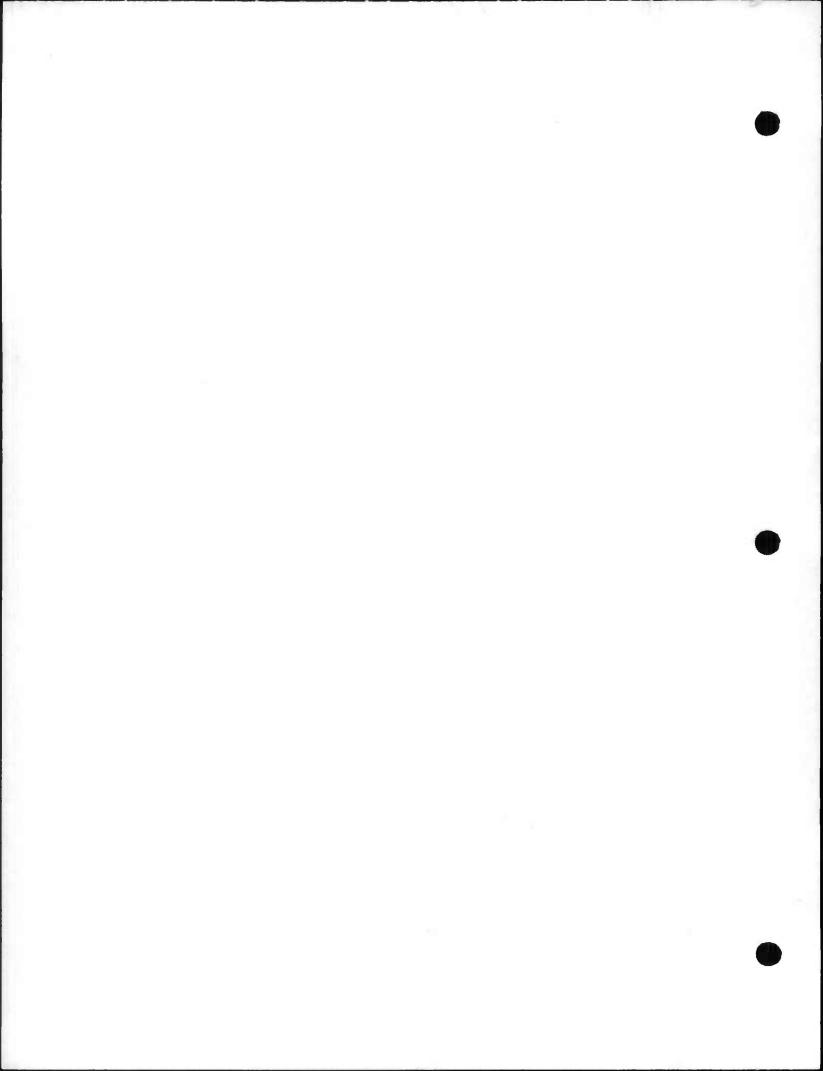
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)				10711	- 01	DLA		2. DATE OF I	DEATH			3. TIME OF DEATH
	Catherine	Virgin	ia Dress	1er						March	DA	199	YEAR	8:35 AM
	4. SOCIAL SECURITY NUME		5. SEX		. lest birthday)	IF UNDE	1 YEAR	IF UNDER	1 24 HRS.	7 DATE OF B	HOTH		8. BIRTH	PLACE (State or Foreign
	215-82-0355		1 🗆 M 2 🗔 F	9	5 YRS.	MONTHS	DAYS	HOURS	MIN.	July	3, 1	899	Country	" Md
~	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
0	138 Newburg Avenue					Catonsville Baltimore						timore		
E C	10e. STATE 10b. COUNTY				10c. CIT	c. CITY, TOWN OR LOCATION 10d, INSIDE CIT							10d. INSIDE CITY	
DIRECTOR	Md Baltimore					Catonerillo					LIMITS?			
4	10e. STREET AND NUMBER						101	ZIP COD	E			10g. CITI	ZEN OF W	THAT COUNTRY?
FUNERAL	138 Newburg Avenue							212	28		USA			
Ē	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2				ARMED	13.	WAS DEC	ENOENT (OF HISPAN	IC ORIGIN? (S	pecify Yea	or No-	14. RACE Black	- American Indian, White, atc.
B	3 🔀 Widowed 4 🗌 Divo		IF YES, OIVE V	AR OR DATES	-2.				Specify		,,		Specif	y:
		EDENT'S EDUC		18a	. DECEDENT'S	USUAL O	CCUPATIO	ON		16b. KIN	D OF BUS	INESS/IND		nite
	Elementary/Secondary (6	y highest grade 0-12)	College (1-4 or 5	.)	(Give kind of life. Do NOT u	work done se retired.)	during mo	st of working	ng					
COMPLET	12				Ho	Homemaker					Own	Hom	e	
S	17. FATHER'S NAME (First, M	liddle, Last)				18. MOTHER'S NAME (First, Mid						Surname)		
BE	George Neum									ne Bee				
2	19a. INFORMANT'S NAME (Caton				21.228
	20e. METHOD OF DISPOSIT			005 014	CEAND DATE				cre,					
	1 □XBuriel 2 □ Crematio 4 □ Donation 5 □ Other	crematory or c				v		DATE 20c. LOCATION — City or Town, Stata 3/14 Baltimore, Md.						
)	21. SIGNATURE OF FUNERA	outile	22. NAME AND ADDRESS OF FACILITY											
Viter & Cold Mar 11							ter1	ing	Asht	on Fun	eral	Hom	e Md.	. 21228
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest,													
	snock, or heart failure. List only one cause on each line.												Onset and Death	
	disesse or condition resulting in death)	→ ,	CVA											
				(OR AS A COA	SEQUENCE O	F):								
8	Sequentially list conditi	ions,	ASCV	OR AS A COM	SECULENCE O	E.								
¥	If any, leeding to Immed cause. Enter UNDERLY!	MG					Hm	10						
Ĕ	CAUSE (Disease or Inju that initiated events	י ביי	CARD.	(OR AS A CON	SEQUENCE O	P):	,,,,							
CERTIFICATION	resulting in death) LAS	T (f											
- 11	PART II. Other aignifica	nt condition	s contributing to	deeth but n	ot resulting	In the ur	derlying	Cause (alven in f	Part I 24s	. WAS AN	umanev	0.45	WERE AUTOPSY FINDINGS
N N						(110 01	i donymą	y caese ;	Araci iti i		PERFORI	MED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
										- 10	YES 2	(PNO		OF DEATH?
≥	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF D	EATH Y	S \square	NO F	LINC	FRTAIN					1 TYES 2 NO
Ž I	25. WAS CASE REFERRED TO				LACE OF DEA			0110	EKIZH					
S	EXAMINER?		HOSPITAL:	ER/Outpatlan	t 3 🗆 DOA	OTHER	R: aing Hom	. 5 X R	aldenca (6 Cher (Spe	ecify)			
PHYSICIAN:	27. MANNER OF DEATH	esale"	28a. DATE OF (Month, D		28b. TIN		28c. INJ			28d. DESCRIE		JURY OCC	CURED	
B		Pending Investigation				М	1 🗆 1	'ES 2 [NO					
		Could not be determined	28e. PLACE O building,	F INJURY — A atc. (Specify)	t home, term,	street, fact	tory, offici			28t. LOCATION City or Tox		nd Number	or Rural Ro	oute Number,
3 Suicide 4 Homicide detarmined building, atc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated.														
3			-64	uminimion and	/or investigation	on, in my c	pinion, d				place, and	dua to th	e cause(a)	and mannar as stated.
ᇤ	296. LICENSE NUMBER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 21/2967 21/3/967								(Month, Day, Year)					
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALL	E OF DEATH	ITEM 27) /Tvna	Print)		9	04	6/		1	1151	190
	(//		AW 58				U B	VE	R	PLTA	mo	2/	228	- 1
	31. DATE FILED (Month, Day,	Year)	32 MEGISTRA	R'S GRAZUR	7			A ve	707	1-10,	9	04/0	(or 0	
	MAR 1 4 1995 July Davis Cardell													



the Presence are mending physician. BALTIMORE, MARYLAND 27215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained to THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonit.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified. DIVISION OF VITAL RECORDS, P.O. BOX 68769

blh	Items	1	3	9a,	g-721 ,	3-	14-95,	per	f.h	dr
FOR					CTATE	0E	MADVI	AND /	DEDADI	FRACA

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	William Fran		-Deba	ulite	Baufre	Mar 0		5 1515 M			
		5. SEX 1 M 2 D F 72	(In yrs. lest birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)			
		05-19-1922 Maryland									
Œ.	9e. FACILITY NAME (If not Institution, give street and number) Johns Hopkins Bayview Medical Center Hookins at Bayview Baltimore Baltimore							9c. COUNTY OF DEATH			
5		A									
DIRECTOR	Maryland Balti	imore		TY, TOWN OR LOCA ndalk	TION			10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER		I. ZIP CODE		1 ☐ YES 2 💢 NO						
FUNERAL	1001 Towerwood Cou	ırt			21222		United States				
5		12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify Y	es or No- 14.	RACE — American Indian,			
BY	1 Never Herried 2 XMerried 3 Widowed 4 Divorced	FORCES? 1 X YES			S 2 XNO Specific	in, Puerto Ricen, stc.) y:		Specify:			
	15. DECEDENT'S EDUCA	TION	WWII	S USUAL OCCUPATI	ON	1 45 KMD 05 B	USINESS/INDUST	White			
E	(Specify only highest grade co	ompleted) College (1-4 or 5+)	(Give kind of life. Do NOT o	work done during muse retired.)	ost of working						
)ĕ	8 years		Plumbe	r		Baltimo	ore City	y Government			
E COMPLETED	17. FATHER'S NAME (First, Middle, Last) James Marion DeBat	ifro			18. MOTHER'S NA	ME (First, Middle, Maide	n Surname)				
	19e. INFORMANT'S NAME (Type/Print)	TILE				e Fitzpatı					
2	Mrs. Helen M. DeBa	aufre	1001	g address (Street Towerwoo	and Number or Rural I d Court I	Aoute Number, City or To Baltimore	wn, State, Zip Coo Maryla	end 21222			
	20a, METHOD OF DISPOSITION	206	. PLACE AND DATE	OF DISPOSITION (N	eme of	DATE 20c. L	OCATION — City	or Town State			
	1 Burlel 2 Cremation 3 Remove 4 Donation 8 Other (Specify)	al from State H1	elitop ^o s	ervice C	orporation	on3/10 Tov	son, Ma	aryland			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	of Duno	of Dundalk, Inc.								
	- Cocard PCO	and	-					yland 21222			
23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, abock, or heart feliure. List only one cause on each line.											
	anoon, or nount foliate. Ele	at only one cause on e	ach line.		da or dying, sec	ii aa coidiec di tes	piratory srreat.				
	IMMEDIATE CAUSE (Finel	at only one cause on e	ach line.					Interval Between Onset and Daath			
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3. TIME OF DEATH

BIRTNPLACE (State or Foreign
Country)

10d. INSIDE CITY LIMITS? 1 YES 2 NO

MARYLAND

10g. CITIZEN OF WHAT COUNTRY?

9c. COUNTY OF DEATH BALTIMORE

10 30 AM

2. DATE OF DEATH DAY MONTH 10, 1995

Dorsey

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (MONTE Day, 104") 1995

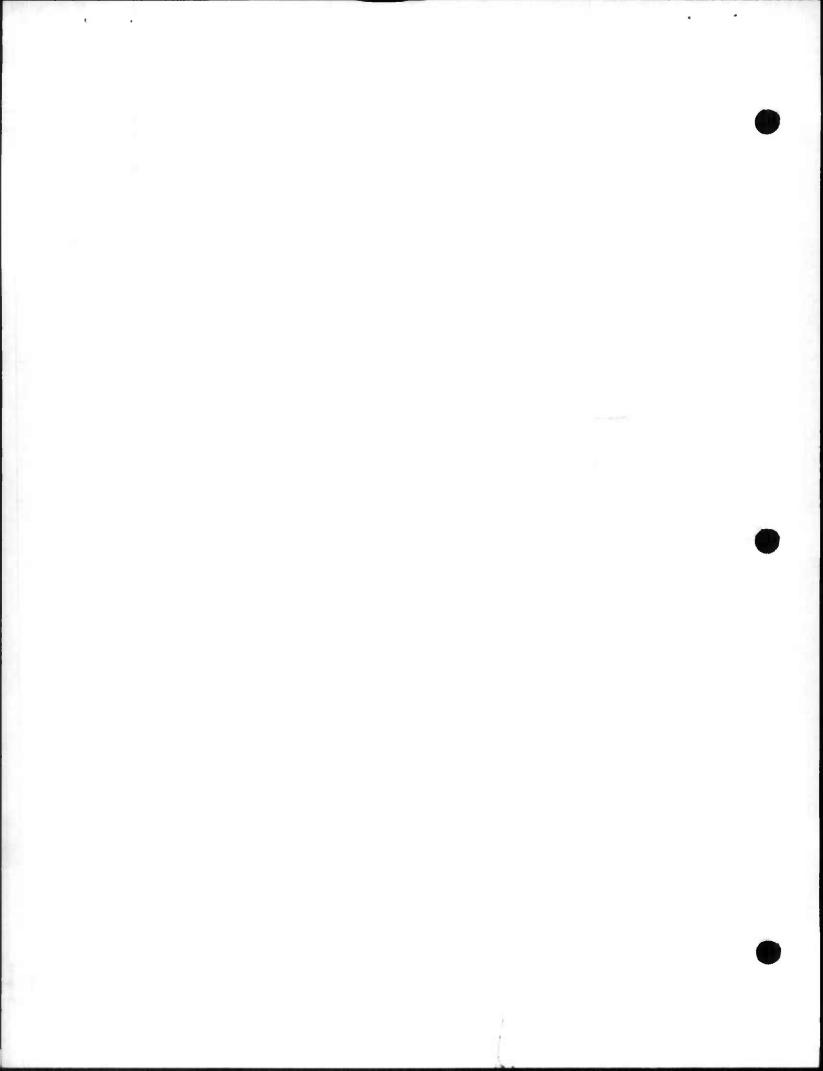
John Rule

DIVISION OF VITAL DECORDS

		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER 1 Y	/EAR	IF UNDER	24 HRS.	7. DATE OF		
		214-34-5793	1 □XM 2 □ F	60	YAS.	MONTHS E	AVB	HOURS	MIN.	July		93/
3 should	BY FUNERAL DIRECTOR	9a. FACILITY NAME (If not institution, give st	reet and number)									9c. CO
		34 Snowberr	v Court			Co	cke	ysvi	116			В
1, 2,		RESIDENCE OF DECEDENT							110			D.
permit. Pages 1,		10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCATI	ON				
A. F			'IMORE		CO	CKEYS	VIL	LE				
T per		10e. STREET AND NUMBER					10f.	ZIP CODE				10g. CI
an. Transi		34 Snowberry Court 21030 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specific Veg or In										
Z15-UUZU attending physician. se as the burial-transit		1 Naver Married 2 Married 3 Widowed 4 Diverced	12. WAS DECEDEN FORCES? 1 IF YES, OIVE V	XYES 2	2 NO If yes, specify Cuban, Mexican, Puarto Rican, etc.)							a or No—
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AND A the hospital o detached for once.	MP		4	E	Executive Owner					A	dver	tisi
the hospital detached for	8	17. FATHER'S NAME (First, Middle, Last)						16, MOTH	ER'S NAI	NAME (First, Middle, Malden Surname)		
F A A	BE		Henry Do	rsey, J	r.				Ι	Dorothy Stewar		
retained 5 should	2	19a, INFORMANT'S NAME (Type/Print)	19	b. MAILING	ADDRESS (S	treet an	d Number	or Rural R	loute Number,	City or Tou	n, State, 2	
	۲	Mary Molly Dorse		34 S	nowbe	rry	Cou	rt,	Cocke	ysvi.	11e,	
Seath. Page 6 may be funeral director, page xaminer must be		20a. METNOD OF DISPOSITION 1 Dering 2 Cremation 3 Ramo	20b. PLACE	ACE AND DATE OF DISPOSITION (Name of ry, crematory or other place) Andrew's Cemetery							CATION -	
. Page 6 ma ral director, p		4 Donation 6 Dother Specify)		At Ai	ndrew					MAR MAR	Le	onar
death. Pag the funeral diff.		21. SIGNATURE OF JUNEAU SERVICE LIC	ENSEE (1 Var	4			ADDRES		1 Hom	0	
		D 2944	an Wy Cl	ary		-				Rd.,		~ m i
5 7 E 5		23. PART I. Enter the diseases, or c	omplications the	t caused the de	eth Do n	ot enter the	e mod	le of dyle	ng, auch	ea cerdie	or reap	Iratory a
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he law requires has been sign Dept. of Heal	AN: N	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S I NO		UNC	RTAIN			
	X	25. WAS CASE REFERRED TO MEDICAL				N (Check only						
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NG PHYSI fler this c eath with marked,	ВУБ	1 Netural 6 Pending 2 Accident Investigation	(MOIRI, D	ay, reer)	INJI		WOR YE		NO			
NDING I: After r death		3 Suicida 6 Could not be	26a. PLACE O	F INJURY — At he	me, farm, s	treet, factory,	office			28f. LOCATI	ON (Street	and Numbe
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St tem 28 is marked, or it	ETED	4 Homicide detarmined	Dallolly,	28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION City or Tou						own, State)		
DIRE DIRE	1 1	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge de	ath occurre	d at the time	data a	and place	and due	to the course	a) and ma	
로 내가 보	COMPL	(Check only one) 2 MEDICAL EXAMINER										
TO THE HOSPIT TO THE FUNER DE filed within 7		29b. SIGNATURE AND TITLE OF CERTIFIER					-	29c. LICE	_		,,	
표 표 등 등	8	No IVE	1-000 W	Cd	to 1.			Zac. LICEI	TA NUM	DER		29d, DA
223	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	E OF DEATH OTE	M 27) /Time	Print		U	10	0.1		
0		David C F++		D COO	ar, (1)//10.	1-16		_	4.			

32. REDISTRAR'S SIGNATURE

USA 14. RACE — American Indian, Black, White, stc. Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY Advertising Agency rothy Stewart te Number, City or Town, State, Zip Code) ockeysville, MD 21030 20c. LOCATION — City or Town, Stata Leonardtown, MD Rd., Timonium, MD 21093 a cerdiec or reapiratory arrest, Approximate Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO d. DESCRIBE NOW INJURY OCCURED H. LOCATION (Street and Number or Rural Route Number, City or Town, State) he cause(a) and manner as stated. e, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 600 N. Wolfe St., Balto., MD 21205 (Oncology 147) DHMH-16 Rev 1/89



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TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

	REGISTRAR	CE	ERTIFICAT	E OF	DEATH	REG. NO.					
	1. OECEDENT'S NAME (First, Middle, Lest) PHILIP	M. DiGI	iGIORGIO			2. DATE OF DEATH DAY	9 5	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. SEX 220-22-7142 1 💢 M 2	0,7	YRS. MONTHS	DAYS I	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1 - 6 - 30	8. BH Co M A	THPLACE (State or Foreign untry) RYLAND			
TOR	9a. FACILITY NAME (If not institution, give street and number 2502 FOX ROAD RESIDENCE OF DECEDENT	·)	9b. CIT	Y, TOWN OR	LOCATION OF DEA	ATH	HARF C				
DIRECTOR	MARYLAND HARFORD		10c. CITY, TOWN	OR LOCATIO	N			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	25_2 FOX ROAD				1047		10g. CITIZEN OF WHAT COUNTRY?				
B	1 Never Merried 2 Merried FORCES?	DENT EVER IN U.S. ARI 1 X YES 2 N VE WAR OR DATES KOREA	MED 13.	ACE — American Indian, ack, White, etc. pecify: I , E.							
	15. OECEDENT'S EDUCATION (Specify only highest grade completed)	(G/	CEDENT'S USUAL O	during most	of working	16b. KIND OF BUSI	NESS/INDUSTR	′			
COMPLETED	Elementary/Secondary (9-12) College (1-4 + 2	or 5 +)	EMAN					LESS STEEL			
႘	17. FATHER'S NAME (First, Middle, Last) DOMINIC DIGIORGIO				MARY G	IE (First, Middle, Maiden S MIID ⊏ V	Surname)				
B	19a. INFORMANT'S NAME (Type/Print)	198	MAILING ADDRES			oute Number, City or Town,					
임	MRS. MARY LOUISE DiG										
	20a METHOD OF DISPOSITION 1 🖄 Buriel 2 🗆 Cremetion 3 🗀 Removal from State 4 🗋 Donation 5 🗀 Other (Specify)	20b. PLACEA Cempetery, crea	AND DATE OF DISPO	SITION (Name			ATION — City on				
	Manyoure of Funeral Service Licenses	nousk	. k	KACZO		FUNERAL		MD 21221			
ERTIFICATION	23. PART I. Enter the diseases, pr complications that caused the deeth. DD not enter the mode of dying, such as cardiac pr reapiratory erreat, abock, pr heart fellure. List only one cause pn each line. Approximate intervel Between Onset and Death disease or condition, reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventer resulting in death) LAST										
O	PART IV. Other algnificant conditions contributing	n to death but not r	equitibal la the u	ndorlulno e	ance alves in f	Part I. 24a, WAS AN A		+			
DICAL	(hronic Obs)	ructive	////	moening c	_	PERFORM	AED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE			
ME	DID TOBACCO USE CONTRIB	UTE TO CAU	SE OF DEA	TH YE	S NO	rest.	Χνο	OF DEATH?			
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL	:	OTHE		E OF DEATH (Che	ck only one)					
148	1 YES 2 NO 1 Inpatient	2 ER/Outpatient 3 E OF INJURY	□ DOA 4 □ Nu	rsing Home		Other (Specify)					
BY P	1 Natural 5 Pending (Mon	th, Day, Year)	26b. TIME OF INJURY M		37 S 2 □ NO	28d. DESCRIBE HOW IN					
ETED	4 Homicide determined	CE OF INJURY — A1 hor ling, atc. (Specify)	ma, tarm, street, tac	tory, office		26t. LOCATION (Street an City or Town, State)	od Number or Rur	al Route Number,			
COMPLETED	29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best							e(s) and manner as stated,			
O BE	296. SIGNATURE AND TITLE OF CERTIFIER WWW. LL. W. W. W. W. W. W. W. W. W. W. W. W. W.	7		2	9c. LICENSE NUMI	2.7	≥94, DATE SIGN	D (Month Day, Year)			
	30. NAME AND ADDRESS OF PERSON, WHO COMPLETED	CAUSE OF DEATH (ITEM	M 27) (Type, Print) MPH	10	4 Pl	untree	Rd	2/0\$5			
	MAR 1 4 1995 Julia otwal	TRAR'S SIGNATURE									



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT	AL HYGIENI
CERTIFICATE OF DEATH	REG NO

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIE						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	OTTO		Ι	DAVIS	SR.	MARCH 6,	1995					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		HRTHPLACE (State or Foreign				
	237-50-4367	1X M 2 DF 6:	2 YRS.	(Month, Day, Year)	ber) Country)							
	99. FACILITY NAME (If not institution, give a	treet and number)	10 1-32 N									
<u>۳</u>	THE JOHNS HOPKIN	IS HOSPITAL					JC. COOK!!!	1//0				
15	THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT											
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
	ma.	Ma. MA BANTO										
¥	10e. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
Ü	1411 ENSO	r 5+.			2/2	202	20	.5.				
FUNERAL	11. MARITAL STATUS	12. WAS OECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify)		RACE — American Indian, Black, White, etc.				
BY I	1 Never Married 2 Married 3 WWidowed 4 Divorced	IF YES, GIVE WAR OR DA			3 2 O Specif							
				1				Black				
COMPLETED	15. DECEOENT'S EOU (Specify only highest grade	completed)	(Give kind of	USUAL OCCUPAT work done during m	ON ost of working	16b. KIND OF B	USINESS/INDUSTI	RY				
12	Elementary/Secondary (0-12)	College (1-4 or 5+)	#fe. Do NOT u	se retirea.)	1.		NIA					
ME	17. FATHER'S NAME (First, Middle, Last)		un	emfas	w		11/11	,				
	17. PATHER'S NAME (FIRST, MIDDIE, LAST)	Devis		0	16. MOTHER'S NA	ME (First, Middle, Meide	on Surname)					
BE	- JIMMY	LAVIS			m	ndy "	0.1111	gm s				
2	190. INFORMANT'S NAME (Type/Print)	/. e	19b. MAJLING	ADDRESS (Street	and Number or Rural	Route Number, City or To	wn, State, Zip Code	"				
	1041		<i>9</i> / 4	10 qu	ANTICO	FYE O	110.M	2/215				
	20a METHOD OF DISPOSITION 1 M Burlet 2 Cremation 3 Remo	oval from State cert	PLACE AND DATE		ame of	30ATE 20c. L	OCATION — City					
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGE	DAITIS	nore C	eme!	195 1	30/10.	nd				
	21. SIGNATURE OF PONERAL SERVICE LIC	ENSEE		22. NAME A	NO ADDRESS OF FA	CILITY	lome	64 pr. md 2121 3				
	Talsun	Betts		1/12	IN. CAR	line ST	SAW	md essix				
	23. PARTLI Enter the diseases, or o	complications that caused	the death. Do i	not enter the me	ode of dying, auc	h as cerdlec or res	piratory errest,	Approximate				
	snock, or heert failure. IMMEDIATE CAUSE (Final	List only one cause on ea	nch line.					Interval Between Onset and Deeth				
1 1	disease or condition											
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	F):				IVAI				
2		1.SCHE	MIL B	DINFI_				1 DAY				
임	Sequentially list conditions, france, leading to immediate ISCHEMIL BOWEL Due to (or as a conscouence of):											
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	ATHER	DSCLERO	TIC VE	MELDU	DUE		1 YEAR				
트	that initiated events		CONSEQUENCE OF									
CERTIFICATION	resulting in death) LAST	d										
Ö	PART II. Other algnificent condition	a gentelbutten to doub b										
18	COPD FIAL	Alautio D	of the treating	In the underlyin	g ceuse given in		N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
MEDIC	COPD, E70H	movit, P	שומונני	pervir	arjose	1 YES	2 240	OF DEATH?				
				\$. a				1 TES 2 NO				
PHYSICIAN:	DID TOBACCO USE CONTE			S NO [UNCERTAI	4 D						
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:								
YSI	1 YES 2 O	1 Inpetient 2 ER/Outp	etient 3 DOA		e 5 🗆 Residence	6 ☐ Other (Specify)						
표	27. MANNER OF OEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		URY AT	28d. DESCRIBE HOW	INJURY OCCURE					
à	1 Accident 5 Pending investigation			M 1 🗆	YES 2 NO							
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Speci	— At home, ferm, s	treet, lactory, offic	•	281. LOCATION (Stree City or Town, State	end Number or Ru	ral Route Number,				
H	4 Homicide determined					,,	7					
29e. CERTIFIER (Check only one) 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated. 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated. 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated. 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated. 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated.												
												NED (Manth, Days Year)
BE	(/honn	Who M.D			29c. LICENSE NUA		DATE SIG	2/1/01				
유	30, NAME AND ADDRESS OF MERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Tyge,	Print)	-1//		, ,	16/7				
	Themes Innier	TOON LUBK		lime	MD.	Tubnikle	skindh	v. Hamal				
	31. DATE FILED (Month, Day Year)	32. REGISTHAR'S SIGNA					, 401/					
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once.

		FOR	
1	_	STATE	
	_	REGISTRAR	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

					TOATE	-	DEATH		HEG. NO.				
-	1. DECEDENT'S NAME (First, Middle, Lest) William Harrison DeWolff Jr. 2. Date Of Death Month 10, 19								O YEAR	3. TIME OF DEATH			
- 1	212-20-5191	5. SEX 1 🂢 M 2 🗆 F	81	S. last birthday) YRS.	MONTHS 1	DAYS	HOURS MIN.	(Mont)	10, 10	8. BIRTHPLACE (State or Foreign Country) Maryland			
	9a. FACILITY NAME (If not institution, give si	treet and number)			9b. CITY,	TOWN	OR LOCATION OF		10, 1		INTY OF D		
OR O	Roland Park Place	-830 West	40th	Stree							N/A		
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,		40.00									
DIRECTOR	36 1 1 2 2 4 4					ty, town on Location 1timore						10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	10e, STREET AND NUMBER				10f. ZIP COOE				_	10g. CfT	IZEN OF V	VHAT COUNTRY?	
E	830 West 40th Stre	eet					21211			U	.S.A		
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S	S. ARMED	13. W	AS DE	CENDENT OF NISF	ANIC ORIGIN	? (Specify Yea	or No	14. RACE	— American Indian,	
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WA			1	Yes, sp	S 2 NO Spe	cify:	ncan, atc.)		Speci		
	15. DECEDENT'S EDUC (Specify only highest grade		164	DECEDENT'S	work done du	CUPATI	ION ost of working	16b	KIND OF BUS	INESS/INI	DUSTRY		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+) Years		teach	í				school	=			
5	17. FATHER'S NAME (First, Middle, Last)	21					18. MOTHER'S		-	_			
	William Harrison I	DeWolff S	c.				Helen						
BH BH	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street	and Number or Run				p Code)		
2	Mr. Julian L. Lapa	ides					Street					01	
	20a. METHOD OF DISPOSITION		20b. PL/	ACE AND DATE	OF DISPOSIT	TION //	ame of	DAT	F 29c, LOC				
	1 Donation 5 Other (Specify)		Gree	nmount			ory Marc		14 Baltimore, Maryland				
ĺ	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGEE)			22. N Mi	22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Inc.							
	hours os	who Brook			65	00	York Roa	ad, Ba	d, Baltimore, Maryland 21212				
į	23. PART I. Enter the diseees, or o shock, or heart failure. IMMEDIATE CAUSE (Finel	List only one caus	e on esch	line.								Approximete Intervel Between Onset and Death	
	disease or condition resulting in desth)	. Sudd	on	Deat	h	-	Probal	ole	Arn	ith.	nia		
		DUE TO (C	OR AS A CO	NSEQUENCE O	F):) ioo		1	Dail	h- L	1.		
HIFICATION	immediate cause (Finel disease or condition resulting in desth) s. Sudden Death Prubable Arrythmia Due to (or as a consequence of): Di I wed Cardio my pathy - Prubably Bue to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
2	csuse. Enter UNDERLYING	c							+31	ان در	ME		
	that initiated events resulting in deeth) LAST	OUE TO (C	OR AS A CO	NSEOUENCE O	F):								
5		d,											
SAL	PART II. Other significant condition	s contributing to d	eeth but n	not resulting	In the und	leriyin	g csuse given	n Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
5									1 TES 2	M		COMPLETION OF CAUSE OF DEATH?	
N N									/			1 YES 2 NO	
	DID TOBACCO USE CONTE	RIBUTE TO CAU	SE OF D	EATH YE	S 🗆 N	X _{OI}	J UNCERTA	IN 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. F	PLACE OF DEA	OTHER:								
2	1 TYES 2 NO	1 Inpatient 2 I			4 🗆 Nursi	ng Hon	ne 5 Residenc	6 🗆 Other	r (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a, DATE OF III (Month, Day		28b. TIM	E OF 2	W	JURY AT ORK? YES 2 NO	28d. DES	CRIBE HOW IN	JURY OC	CURED		
2 Accident Investigation 3 Suicide 8 Could not be datarmined								nd Numbe	r or Rural F	loute Number,			
-	29a. CERTIFIER					-							
COMPLE	(Check only one) 1 CERTIFYING PNYSIC ONE) 2 MEDICAL EXAMINE	CIAN: To the best of m) and manner as stated,	
DE L	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE N	UMBER 7 (3.3			E SIGNED	(Month, Day, Year)	
2 ∥	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CALISE	OF OF ATM	(ITEM 27) /Tone	Print)		23	1133			- / 1 -	17-3	
	Donna Dow M.D. 63	301 N. Ch	arles	St. S		8 F	Baltimor	e. MD	21212				
	MAR 1 4 1995	37 REGISTRAR	S SIGNATUR	ardell			- S-LIIVI						
		(1)											



DIVISION OF VITAL RECORDS, P.O. BOX 68769 TO THE HOSPITAL OF TO THE FUNERAL DID BE filed within 72 hr

COMPL

BE

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31. DATE FILED (Month, Day, Year)

4 1995

95 07607 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Edna DRAKE March 10,1995 7:10 P 4. SOCIAL SECURITY HUMBER 6. AGE (In yrs. last birthday) BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR DAYS HOURS 1 M 2 F 214-07-2862 79 YRS. March 17,1915 Maryland 9s. FACILITY NAME (If not institution, give street and number 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Franklin Square Hospital Rossville Baltimore County RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. JHSIDE CITY LIMITS? Maryland Baltimore County Middle River 1 YES 2 NO 10e. STREET AND HUMBER FUNERAL 101. ZIP CODE 10g. CITIZEH OF WHAT COUNTRY? 404 Waterswatch Court 21220 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Ho-14. RACE — American Indian, Black, White, stc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

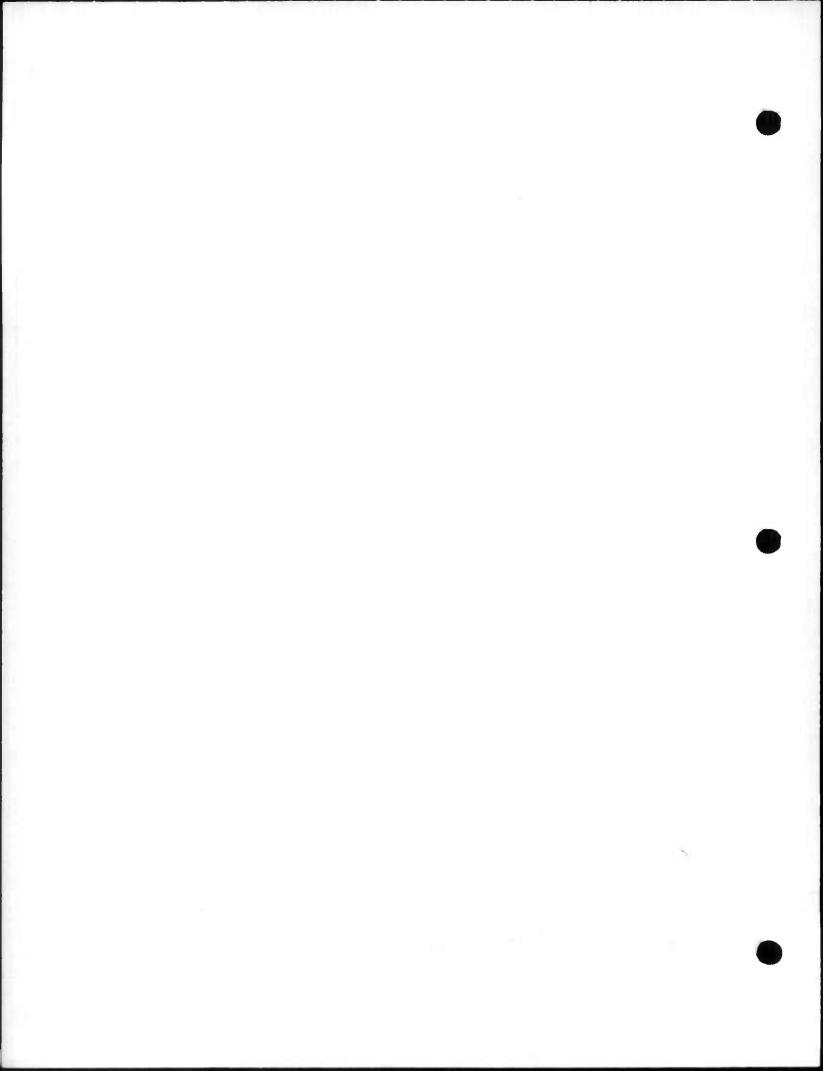
1 YES 2 NO Specify: FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 3 🔯 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIHD OF BUSINESS/IHDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5 +) Drug Manufacturing Machine Operator 3rd Grade Company 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S HAME (First, Middle, Malden Sumame) Joseph McKensie Elizabeth Finze1 品 19s. INFORMANT'S HAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 404 Waterswatch Court, Baltimore, Maryland 21220 Patricia Elizabeth Maher 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State /13/95 1 □ Burlat 2 ☑ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Hilltop Service Corporation Towson, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. HAME AHD ADDRESS OF FACILITY 6415 Belair Road John C. Miller, Inc. Baltimore, Md. -21206 23. PART i. Enter the diseases, or complications that caused the death/ Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one ceuse on each ilne. interval Between **IMMEDIATE CAUSE (Final Onset and Death** disease or condition_ Brainstem cerebrovascular accident 7days reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF): 7 days CERTIFICATION Sequentially list conditions, if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO Hypertension, insulin dependent diabetes COMPLETION OF CAUSE 1 ☐ YES 2 💢 HO → OF DEATH? Sepsis 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 TES 2 NO 1 🖵 Inpetient 2 🗆 ER/Outpetient 3 🗆 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1X Hatural 5 Pending Investigation M 1 YES 2 HO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED a Could not be 4 Homicide 29s. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and dus to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

Cepon Me R D 1767 March 10,1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Stacey Dyson 9000 Franklin Square Dr. Baltimore, Maryland 21237

29c. LICENSE HUMBER

29d. DATE SIGNED (Month, Day, Year)

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020	HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with mours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transi within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remoral.	AANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at onee.
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>	ICIAN	the S	. Or
DIVISION OF VITAL RECORDS, P.O. BOX 68760	NG PHYS	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	marked
20	LENDI	DR: A	8 is
	DR AT	DIRECT hours at	Item 2
	SPITAL	ERAL in 72	T. If
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COMPLETED

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Pages 1, 2, 3 should

95 07608 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 3 95 ENNOLS 9:23A H CHARLES 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 - F 2-2 6.4 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BATTO DIRECTOR EDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2123 229 ou 21 -5 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Obtan, Maxican, Puerlo Rican, etc.) 1 YES 2 Specify: 1 Never Married 2 Merried
3 Widowed 4 Divorced BY BE COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ry (0-12) College (1-4 or 5+) 9 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of rial 2 Cremation 3 Ren Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Betts EunenAl 1129N. CAROLINE 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) CARDIAC ARREST OMINS DUE TO (OR AS A CONSEQUENCE OF): HEART BLOCKED 1 MONTH PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING ANOXIC ENCEPHALOPATHY MONTH CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? ASPIRATION PNEUMONIA 1 TYES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: BY

1 VES 2 NO	1 Ninpatient 2 ER/Outpatient 3	DOA 4 Nun	sing Home 5 🗆 Residence	8 Other (Specify)
7. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED
3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — At hor building, etc. (Specify)	me, ferm, street, fact	tory, office	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER
(Check only

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

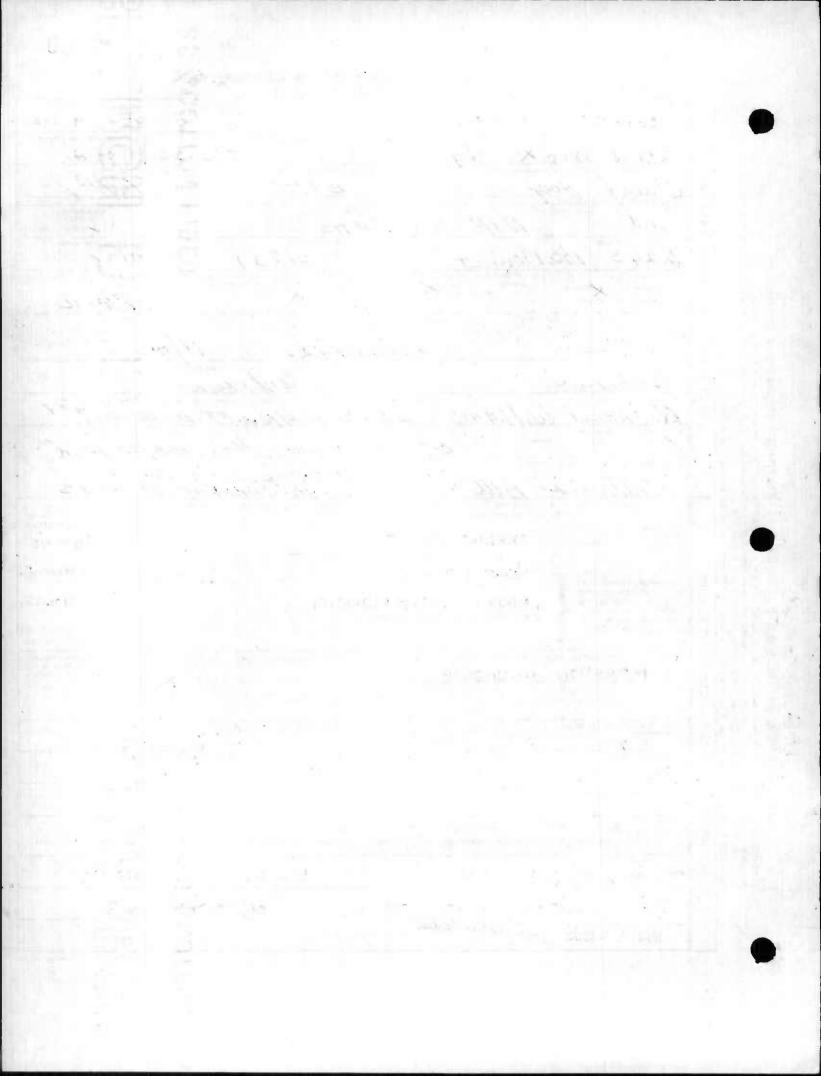
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a mesione expansion on the desig	or examination and/or investigate	non, in my opinion, death occurred at the time, date end plac	e, and due to the cause(s) end manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER OLIVERY VOLUMENTS	MD	29c, LICENSE NUMBER D 45535	29d. DATE SIGNED (Month, Day, Year)

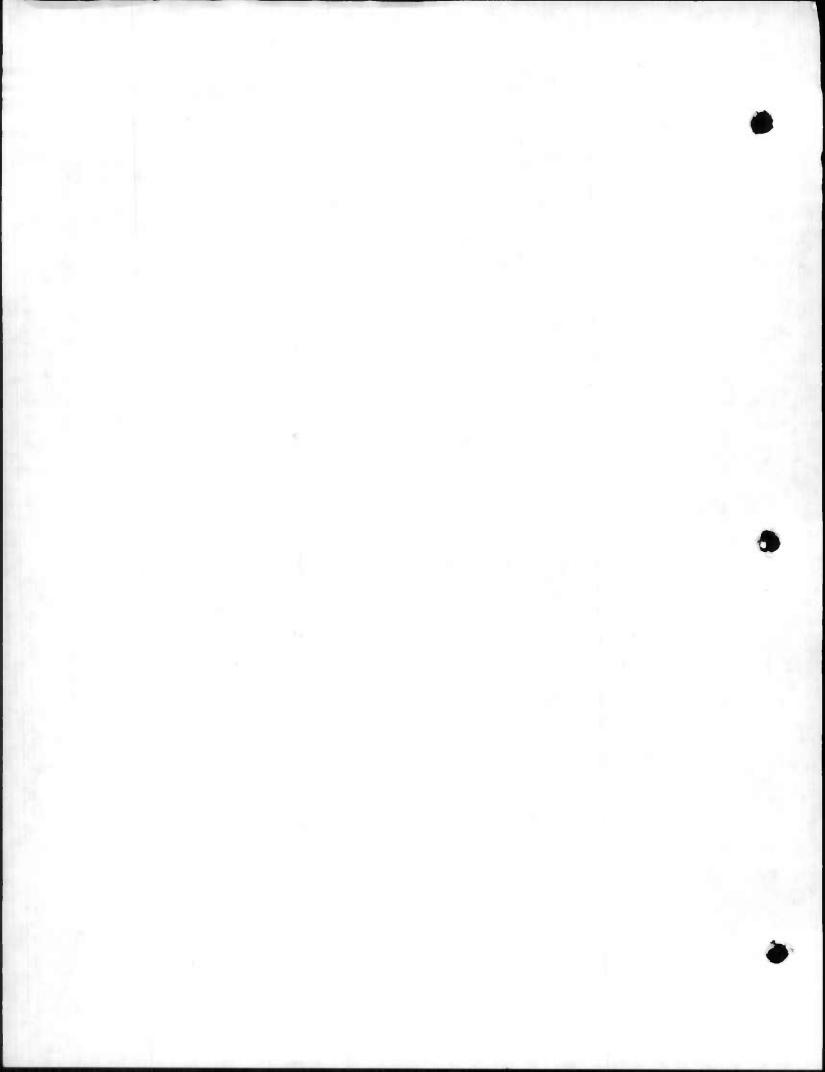
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30.	NAME AND	ADDRESS	OF PERSON V	OHN	COMPLETED	CAUSE	OF	DEATH	(ITEM	27)	(Тура,	Print)

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MAR 1 4 1995	Juin 32.	FRISTELES - FRANCISE!		

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CERTIFICATE # 95-07609
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CERTIFICATE #



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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31. DATE FILED (Month, Day, Year)

4 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

on les

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32. REGISTRAR'S SIGNATURE

Davolson Revolate

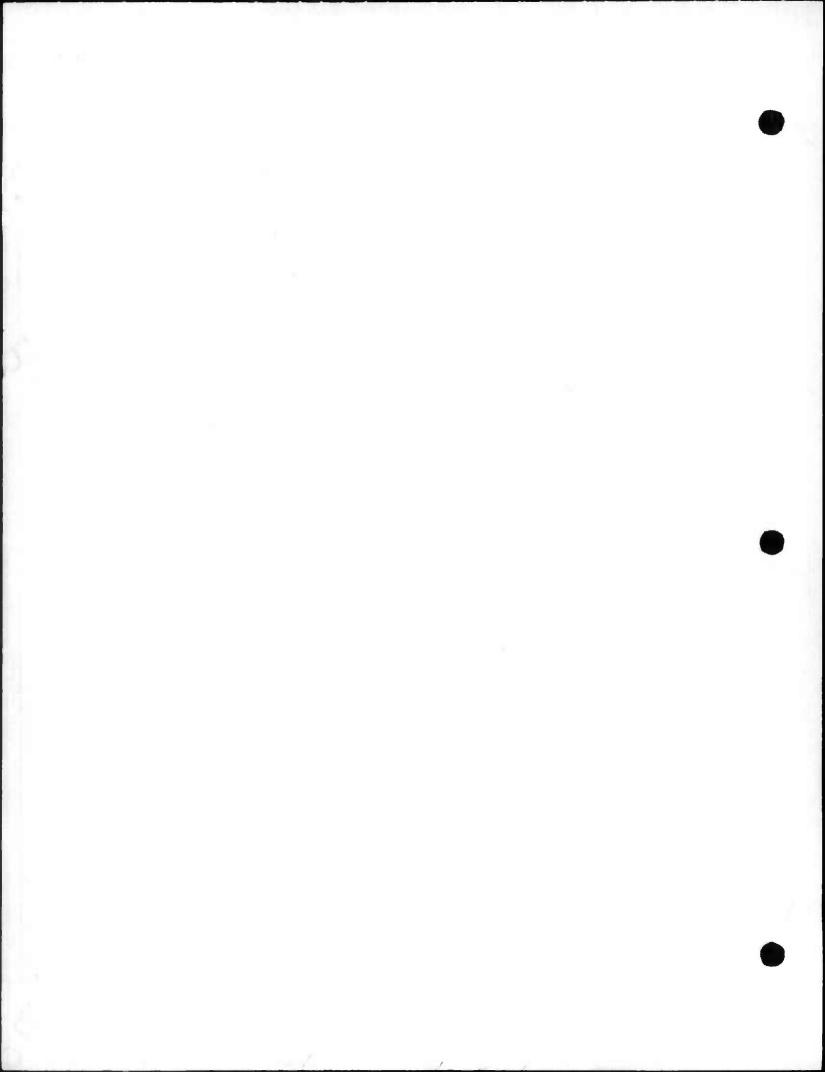
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH MAR. WILLIE FRANCIS ANN 2107 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State pr Foreign IF UNDER 24 HRS. 19-66-7628 DAYS 1 M 2 WF 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST.AGNES HOSPITAL CHEST PAIN BALTIMORE CITY RESIDENCE OF DECEDENT 109. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 VES 2 NO Maryland mor FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 212 12. WAS DECEDENT EVER IN U.S. APMED FORCES? 1 YES 2 YNO 11. MARITAL STATUS 13. WAS DECENDENT, OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Caban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES В YES 2 NO Specify: 3 Widowed 4 Olvorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Dp NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRIN (Specify only high dary (0-12) ĸe 17. FATHER'S NAME (First, Middle. 18. MOTHER'S NAME (First, Middle Idea Sumame 8 2 METHOD OF DISPOSITION DATE 20s. LOCATION 4 Doneti es 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
TOCOPOL LIRU 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph Funera 23. PART LEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory stress shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disesse or condition Morbid obesita resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN IT 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 YES 2 NO OTHER: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation ВУ 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined TO THE FUNERAL DIRECTOR: A DE FIRED WITHIN 72 hours after IMPORTANT: If Item 28 is 4 Homicide 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF SERLIFIER

29d. DATE SIGNED (Month, Day, Year)

MARCH 10,1995

29c. LICENSE NUMBER O.C.M.E

PENN STREET, BALTIMORE, MARYLAND 21201



DIVISION OF VITAL RECORDS, P.O. BOX 68760

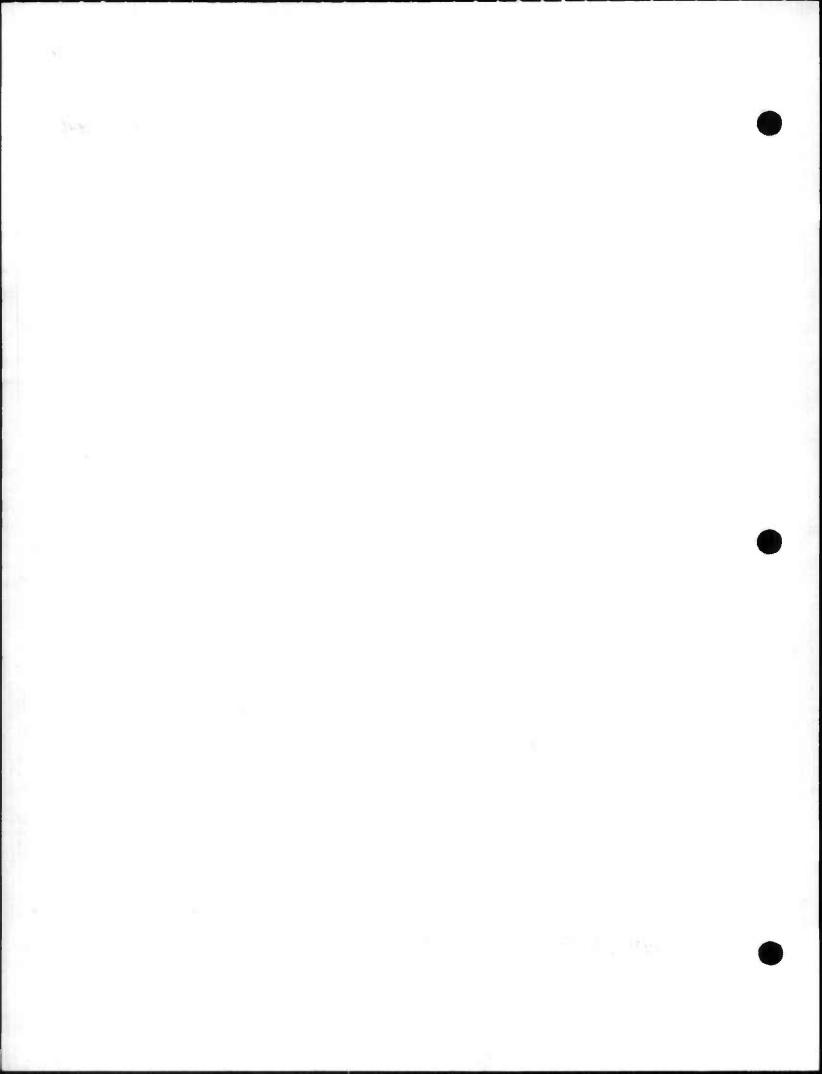
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hyglene prior to burial, cremation, or removal.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

							IOAIL	01 0	LAIII	_	HEG. NO			
	,	1. DECEDENT'S NAME (First, Middle, FLOREN		SOPHIE	FL	URY				2. DATE		AY	95	3. TIME OF DEATH 8.46 A M
		4. SOCIAL SECURITY NUMBER 220 14 8128		5. SEX	6. AGE (In yrs. In 82		IF UNDER 1		OURS MIN.	(Mon	OF BIRTH th, Day, Year) 12 12		Countr	PLACE (State or Foreign 7land
_	.	9a. FACILITY NAME (If not institution,	give st	treet end number)			9b. CITY, 1	OWN OR L	OCATION OF D				NTY OF D	
DIRECTOR		Saint Agnes		spital			Dali	imor	'e 			N/	/A	
REC		10a. STATE 10b. C		N/A			Y, TOWN OR							10d. INSIDE CITY LIMITS?
	- 16					Ba	altimo							1 N YES 2 NO
FUNERAL		100. STREET AND NUMBER 811 South De	an	Street					1224			USA		/HAT COUNTRY?
1 5		11. MARITAL STATUS		12. WAS DECEDEN	NT EVER IN U.S. A	RMED	13. W	S DECENC	DENT OF HISPA	NIC ORIGI	N? (Specify Yes	or No	14. RACE	— American Indian,
Æ		1 Never Married 2 Merried 3 Widowed 4 Divorced		IF YES, GIVE	MAR OR DATES				y Cuban, Maxic ∑ NO Speci		Hican, etc.)		Specific	
		15. DECEDENT'S (Specify only highest	grade	CATION completed)	16a. D	ECEDENT'S Give kind of	USUAL OCC work done du se retired.)	JPATION ing most of	f working	160	b. KIND OF BUS	SINESS/INC		
APLET		Elementary/Secondary (0-12)		College (1-4 or 5		louse					At Hom	е		
COMPL		17. FATHER'S NAME (First, Middle, La	st)	harles He				18	MOTHER'S N			Surneme)		
ed at		19a. INFORMANT'S NAME (Type/Print		rar les ne		_			Marye					
examiner must be notified at once. TO BE COM		LeRoy J. Flu			1				Number or Rural Dad Dun				Code)	
å	ľ	20s. METHOD OF DISPOSITION			20b. PLACE	ANDDATE	OF DISPOSITI	ON (Name o	of	DAT	E 20c. LO	CATION -	Cify or Tor	wn. State
E		1 Surial 2 Cremation 3 4 Donation 5 Other (Specify)			cemetary, ci	ematory or o	ther place) Part c	f_Je	SUS CE	m 3	-14-95	Dunc	dalk,	Md.
E I	ļ	21. SIGNATURE OF FUNERAL SERVI	CE LIC	ENSEE	/		Cha	ME AND A	S.Zei	LOS	o Com	T		
		Charles	_	D- 7	سللت		901	S.C	onklin	a St	Pal+	> Mo	9	
Jedici L		23. PART i. Enter the diseases shock, or heart fail	, or c	omplications the	at caused the duse on each lin	eath. Do i	not anter th	e mode	of dying, suc	ch ea can	diac or reepi	ratory arr	rest,	Approximete interval Between
E E	İ	IMMEDIATE CAUSE (Final disease or condition		0	11/5/11	11 11	1,4							Onset and Death
ent,		resulting in death)	4	n. Due to	OF AS A CONSE	OUENCE O) / /							Week
2 Z		Amortina saturna torrettera en			N HOD			4	MPHO	MA	1			10 YEARS
ws any Injury, or other traumatic event, the medical IEDICAL CERTIFICATION		Sequantially list conditions, if any, leading to immediata cause. Entar UNDERLYING		DUE TO	(OR AS A CONSE	OUENCE O	F):							
IFIC IFIC		CAUSE (Disease or injury that initiated events	°	DUE TO	(OR AS A CONSE	OUENCE O	F):							
EH S		resulting in death) LAST	L a	i										
- E	1	PART II. Other aignificent cond	dition	contributing to	deeth but not	resulting	in the unde	rlying ce	use given in	Part i.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL											PERFOR		1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
														OF DEATH? 1 YES 2 NO
AN: N		DID TOBACCO USE CO		RIBUTE TO CA					UNCERTAI	N 🛛				
SIC!		25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 ☐ YES 2 ☒ NO	AL	HOSPITAL:			OTHER:							
HYS		27. MANNER OF DEATH		1/Q Inpatient 2	INJURY	26b. TIM		Home 5	☐ Residence		CRIBE HOW IF	LIURY OCC	TURED	
BY PHYSICIAN:) }	1 Natural 5 Pending 2 Accident Investiga	tion	(Month, D			M	WORK?	2 🗌 NO				JOILED	
Z8 IS		3 Suicide 6 Could no 4 Homicide detarmin		28e. PLACE O building,	OF INJURY — AI h elc. (Specify)	ome, ferm, :	itreet, factory	office		28f. LOC City	ATION (Street e or Town, State)	nd Number	or Rural Ri	oute Number,
틸		29a. CERTIFIER (Check only	PHYSIC	CIAN: To the best of	my knowledge, d	eath occum	ed at the time	data and	place, and due	to the car	use(a) and men	ner as stat-	ed.	
														and menner as stated.
E H		296. SIGNATURE AND TITLE OF CER	TIFIER		CAL R	FSIA	SATI	29	60			29d. DATE	E SIGNED	(Month, Day, Year)
_ნ	l	30. NAME AND ADDRESS OF PERSO	N WHO			M 27) (Type,	Print)					- / /	(11)	11) 13
		GILBERT (H)	DIt	C, SAII	UT AGNES	Host	MAZ	900	CATUN	AVE	BARC	TIMON	E, K	10,21229
		31. DATE FILED (Month, Day, Year)	Ē	12. REGISTRA	A SIGNATURE	. 11								
	JL	(MAIX / '2 155	8	James and	- ADV. LAND	-								

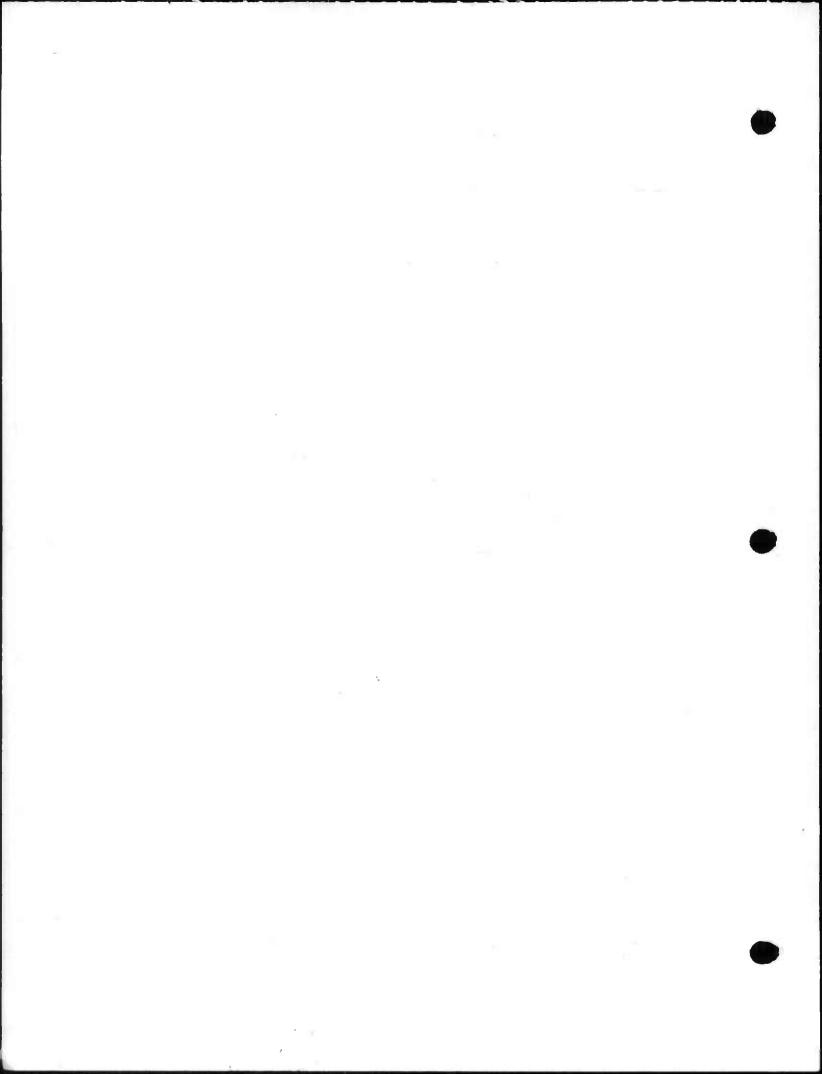


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incompletely filled in by the retained by the burial-transit permit. Pages 1. 2. 3 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
DECEDENT'S NAME (First, Middle, Last)	LOUISE	Fail	2. DATE OF DEATH MONTH DAY

	REGISTRAR		CERTIFIC	ATE OF DEA	NTH .	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)		5	- 1		2. DATE OF DEATH	YEAR	3. TIME OF DEATH			
- 4	(AMERINIS	LOUISE	Ti.	nch		3	12 95	916PM			
1	489-30-7737	□ M 2 □ X 6	MO	UNDER 1 YEAR IF UND NTHS DAYS HOURS	ER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) DEC. 21, 19	8. BIRTI Count MIS	PLACE (State or Foreign			
OR	9a. FACILITY NAME (If not institution, give stree UNIVERS		TAL	BALT	MORE						
ទួ	RESIDENCE OF DECEDENT										
DIRECTOR	MARYLAND n	/a	OWN OR LOCATION SEVER			10d. INSIDE CITY LIMITS? 1 YES 2/ NO					
FUNERAL	100. STREET AND NUMBER 8364	FLINTLOCK	101. ZIP CODE 21144			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yee, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES X NO Specify:			or No— 14. RACI Blac Spec	E — American Indian, k, White, atc. #y: BLACK				
9	15. DECEDENT'S EDUCAT (Specify only highest grade cor		18a. DECEDENT'S USI	UAL OCCUPATION done during most of work	l	16b. KIND OF BUSI	NESS/INDUSTRY				
COMPLETED		College (1-4 or 5+)	Ille. Do NOT use re	IONIST	ang	DEPT. OF	AGING				
	17. FATHER'S NAME (First, Middle, Last) EMMANUEL SHEPARD			18. MO		ME (First, Middle, Maiden S NIA (SWAN					
TO BE	190. INFORMANT'S NAME (Type/Print) LINDA FINCH		19b. MAILING AD 8344	DEER RUN	er or Rural R	Number City or Town, RT, SEVERN	State, Zio Code) MARYLA	ND 21144			
	20a, METHOD OF DISPOSITION XX Burlel 2 Cremetton 3 Remove 4 Donation 5 Other (Specify)	I from State 20b. F	PLACE AND DATE OF D	ISPOSITION (Name of		OATE 20c. LOC	ATION — City or To				
	21. SIGNATURE OF FUNERAL SERVICE LICEN		,	22. NAME AND ADDR	ESS OF FAC	FH1101	E. NORTH	AE.			
\dashv	23. PART I. Entar tha diseases, or com	0	<u> </u>		1	BALTIM	ORE, MAR	YLAND 21202			
	ahock, or heart failure. Lia IMMEDIATE CAUSE (Finai disease or condition resulting in death)	t only ona cause on each	ch line.	enter the mode of d	•		etory arreat,	Approximata interval Between Onset and Daath			
z		DUE TO (OR AS A C						100			
CATIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c.										
CERTIFICATION	that initiated events resulting in death) LAST	OUE TO (OR AS A C	CONSEQUENCE OF):								
	PART ii. Other aignificant conditions of	ontributing to death bu	t not resulting in t	ha undariying causa	giván In E	Part I. 24s. WAS AN A	LITOREY 245	WERE AUTOPSY FINDINGS			
EDICAL		ve Cora				PERFORM	IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
Σ	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	DEATH VEC	C NO M III	CERTAIN			1 TYES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		DEATH TES		CERIAIN						
SICI	EXAMINER?	OSPITAL:	0	THER:							
Ě	27. MANNER OF DEATH	28a. OATE OF INJURY	28b. TIME O		insidence 8	28d. OESCRIBE HOW IN.	JURY OCCURED				
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 YES 2	□ NO						
	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY – building, atc. (Specify	- At home, term, stree	t, factory, office		28t. LOCATION (Street an City or Town, State)	d Number or Rural F	noute Number,			
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL (Check only one) 2 MEDICAL EXAMINER: C	N: To the best of my knowled									
	29b. SIGNATURE AND TITLE OF CERTIPMEN										
O BE	Jula (1)	Needly	-mo	. 12	SENSE NUMI	ent.	≥ 3//2	(Month, Day, Year)			
5	30 NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF BOAT	H (ITEM 27) (Type, Prin	BAH	how	e Mi	0710	042			
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT MAR 1 4 19	995 Jali	Mudeonka	dall	/		/->			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 75 hours are may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compilery flied in by the funeral directs, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene permit committee. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND C	/ DEPAR	TMENT OF H	EALTH AND DEATH	MENT	AL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)				-		E OF DEATH		3	. TIME OF DEATH	
	Vanessa.	Friend				Mar	1 6		YEAR	0515 AM	
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. Is	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH		B. BIRTHPL	ACE (State or Foreign	
		□ M 2 🛣 F 40	YRS.	MONTHS DAYS	HOURS MIN.		727754			o., Md.	
~	9a. FACILITY NAME (If not institution, give street				R LOCATION OF D	EATH		9c. COUNT			
5	University Hosp	1 tal		Balt	imore				N/A		
E	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	ION				10	Dd. INSIDE CITY	
DIRECTOR	Maryland -	N/A		Baltim	ore				1	LIMITS?	
	10e. STREET AND NUMBER			101	. ZIP CODE			10g. CITIZE	N OF WN	AT COUNTRY?	
BY FUNERAL	1014 Druid Hill	Avenue			21201	I		1	USA		
5	The state of the s	. WAS DECEDENT EVER IN U.S. A		13. WAS DEC	ENDENT OF HISPA	NIC ORIG	IN? (Specify Yes	or No — 1	4. RACE -	American Indian,	
7	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES 2 THE STATE OF TH	M O		cify Cuban, Maxica 2 X NO Specif		Rican, atc.)		Specify:	Vhita, etc.	
				1						Black	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	npleted) (Give kind of w	OSUAL OCCUPATION OF COMPANY OF CO		16	66. KIND OF BUS	SINESS/INDU	STRY		
F		College (1-4 or 5+)	e. Do NOT use	n/a				n/a			
Ā	12th 17. FATHER'S NAME (First, Middle, Last)										
ဗ	Samuel Friend				18. MOTHER'S NA		Denni	-			
BE	19a. INFORMANT'S NAME (Type/Print)	1		1000500 (O)						-	
5	Tiffany Toulson		L014	Druid	nd Number or Rural Hill Av	Houte Nui	Balto			21201	
	20a, METHOD OF DISPOSITION			F DISPOSITION (Na		_		CATION — CI			
	1 A Burial 2 Cremation 3 Removal	from State cemetery, cr	rematory or oth	her place)	emotors	73/1	5 Do 1	+ imo	ty or lown.	Maryland	
	21, SIGNATURE OF FUNERAL SERVICE LICENT	NEE / WEST	Jenn	22. NAME AN	ID ADDRESS OF FA	CILITY	Dal	CIMO.	Le,	Maryrand	
	700 516	110004	_	I.ERO	Y O. D'	YETT					
_	7/04040	Mary			LIBER					21207	
	23. PABY I. Enter the diseases, or com sheek, or heart follow. List	plicetions that caused the d	eeth. Do no a.	ot anter the mo	de of dying, euc	h ea ca	rdiec or reepi	ratory erret	et,	Approximate Interval Batween	
	IMMEDIATE CAUSE (Final	< U								Onset and Death	
	disease or condition	240515									
	DUE TO (OR AS A CONSEQUENCE OF):										
S	Sequentially list conditions, b	DUE TO (OR AS A CONSE	OUENCE OF								
A	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	OUENCE OF):							
임	CAUSE (Disease or Injury thet initiated avents	DUE TO (OR AS A CONSE	OUENCE OF):							
CERTIFICATION	resulting in death) LAST										
	0										
PHYSICIAN: MEDICAL	PART ii. Other significent conditione co	ontributing to death but not	reeuiting Ir	n the underlying	ceuse given in	Part i.	24a. WAS AN PERFOR			ERE AUTOPSY FINDINGS AILABLE PRIOR TO	
ă							1 YES 2	□ NO		OMPLETION OF CAUSE F DEATH?	
M									11	YES 2 NO	
ä	DID TOBACCO USE CONTRIB				UNCERTAI	Ν□					
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLA OSPITAL:		OTHER:							
YS		☐ Inpatient 2 ☐ ER/Outpatient	3 🗆 DOA	4 - Nursing Hom	5 🗆 Rasidence	6 🗆 Oth	er (Specify)				
표	27. MANNER OF DEATH 1 💢 Natural 5 Pending	(Month, Day, Year)	28b, TIME INJU	JRY WO	RK?	28d. DE	SCRIBE HOW II	NJURY OCCU	RED		
ВУ	2 Accident Investigation	4. 5. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.		M 1 7							
	3 Suicide 8 Could not be	28a. PLACE OF INJURY — At h building, atc. (Specify)	ome, term, st	reet, tectory, office		281, LO	CATION (Street a y or Town, State)	and Number or	Rural Rout	te Number,	
COMPLETED	100 CENTIFIED										
린		t: To the best of my knowledge, d									
Ö	2 MEDICAL EXAMINER: 0	n the basis of examination and/or	investigation	i, in my opinion, de	eath occured at the	time, dat	te and place, an	d due to the	cause(s) ar	nd manner as stated.	
BE	296. SIGNATURE AND TITUE OF CENTIFIER	0 101	151	7	29c. LICENSE NUI			29d. DATE S	SIGNED (M	onth, Day, Year)	
70	Hmain &	1 yell	11	/	108	6	24	▶ 3	191	95	
-	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITE	ЕМ 27) (Туре,								
	ANDREW K.	MYERS	22	5. 6.	rene 5	T.	BAL	T, M	D	21201	
- 1	MAR 1 4 1995	32. REGISTRAR'S SIGNATURE DEWOLSON RONLOLL									
Щ											

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1	- STATE REGISTRA
	1. DECEDENT'S
r	4. SOCIAL SECU

		REGISTRAR		CER	TIFICA	TE OF	DEATH	REG. NO)			
		1. DECEDENT'S NAME (First, Middle, Last) Mary Eliza	hath F	rancis				2. DATE OF DEATH		3. TIME OF DEATH		
		- DIIIC	~~~				1	March	199	5 840 A M		
		The state of the s		(In yrs. lest bir	YRS, MONT	THE DAYS	HOURS MIN.	/ DATE OF BIRTH (Month, Day, Year) 4/11/05	6.	BIRTHPLACE (State or Foreign Country)		
3 should		9e. FACILITY NAME (If not institution, give stree	et and number)		9b.	CITY, TOWN	OR LOCATION OF D		9c. COUNTY	VIRGINIA V OF DEATH		
1, 2, 3 s	DIRECTOR	8710 Eddington Road	đ			T	owson		Balt	timore		
	[జ 	10a. STATE 10b. COUNTY		10	c. CITY, TO	WN OR LOCA	ITION			10d. INSIDE CITY		
ř. Pa		Maryland Balti	more		T	owson				LIMITS?		
perm	¥	10e, STREET AND NUMBER				10	H. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?		
an. ransit	FUNERAL	8710 Eddington Roa	đ				21234			USA		
physician. burial-transit permit. Pages	필	11. MARITAL STATUS 1 1 Never Married 2 Married	2. WAS DECEDENT EVER II FORCES? 1 YES			13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	a or No- 14	. RACE — American Indian, Black, White, atc.		
	₽	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	- 1		S 2 NO Specif			Specify: White		
r attending use as the	9	15. DECEDENT'S EDUCAT (Specify only highest grade col	TION	16a. DECED	ENT'S USUA	AL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDUS			
_ =			College (1-4 or 5+)	life. Do	NOT use retir	lone during m red.)	ost of working					
hospital ached fo	COMPLETED		/A	Home	emake	r		N/I	1			
det det		17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maiden	Sumame)			
	BE	Robert E. Minor 19a. INFORMANT'S NAME (Type/Print)					Hattie					
should should notified	임	Elizabeth Louise K	nunn				and Number or Rural nia Avenu	Route Number, City or Tow				
may be or. page		20a. METHOD OF DISPOSITION	201	PLACEAND						21234 y or Town, Stata		
9 5 5		1X Buriel 2 Cremation 3 Ramova 4 Donation 5 Other (Specify)	of from State Cen	netery, cremato	ry or other pl	ace)	l Park	3/14/95 Hi				
. Page ral direc		21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE //	OLETAI	io ne	22. NAME A	ND ADDRESS OF FA	CILITY		1107 110		
	ŀ	1/ mistra	1/1	/	1		son Funer		М	- MD 01006		
by the		23. PART I. Enter the diseases, or con	nplications that caused	d the death.	Do not er	nter the mo	Loch Ray	en Bivo.	Towsor	n, MD 21286		
n certificate be executed within nours nding physician and completely filled in Hyglene prior to burial, cremation, or re or other traumatic event, the med		ahock, or heart failure. List only one coupe on each life. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as & conscouence) on:										
and comple burial, cr matic eve	~	To the total and a consequence of the consequence o										
e be execute siclan and conion to buria traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										
he death certificate be the attending physician Wental Hyglene prior to hiury, or other traun	FI	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUEN	ICE OFI:							
th certing ending Hygie or ott	F	resulting in deeth) LAST	10000100							İ		
death e atte hental		DART II Other clearliness are distant										
1 P P T	DICAL	PART II. Other significant conditions of	ontributing to deeth b	ut not resul	ting in the	underiyin	g ceuse given in	Part i. 24a. WAS AN PERFOR	AUTOPSY IMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
ires sign feat	ED							1 TYES 2	the Ho	OF DEATH?		
sh of seen	I: ME	DID TOBACCO USE CONTRIB	SUITE TO CAUSE O	E DEATH	VES [J NO IT	UNCERTAIN			1 TES 2 NO		
he law e has t e Dept m 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF			DINCERIAII	101				
SICIAN: The certificate h the State h the State d, or item	Sic		IOSPITAL:	entient 3 🗆 D	OA 4	HER: Nursing Hom	ne 5 Rasidence	6 ☐ Other (Specify)				
PHYSICI this cer with th	£	27. MANNER OF DEATH	28e, DATE OF INJURY (Month, Day, Year)	281	. TIME OF	29c. INJ	JURY AT	28d. DESCRIBE HOW I	NJURY OCCUR	ED		
After this of death with	BY	1 Natural 5 Pending 2 Accident Investigation					YES 2 NO					
OR ATTENDING PHYSICIAN: The law MIRECTOR: After this certificate has b ours after death with the State Dept tem 28 is marked, or item 23	ETED	3 Suicide 8 Could not be detarmined	28e. PLACE OF INJURY building, etc. (Spec	— At homa, f	arm, street,	factory, offic	a	281. LOCATION (Street a City or Town, State)	nd Number or F	Rural Route Number,		
DIRE	S'E	29a. CERTIFIER (Check only	N: To the best of my know	ledge, death o	coursed at It	he time date	and place, and due	In the causele) and				
	B	one) 2 MEDICAL EXAMINER: C	On the basis of examination	n and/or invest	tigation, in r	my opinion, d	leath occured at the	time, dete and place, an	d dua to the ce	euse(a) and manner as stated,		
1	Ž,	291. SIGNATURE AND SITLE OF CERTIFIER	- A-1	N	. /	/	29c. LICENSE NUN	BER	29d. DATE SI	GNED (Month, Day, Year)		
5535	0	Argus 2 Malan n	Intity matic	JEXAI	MINE		DOI)80	May	h 1/1/98		
		STANK Z.	PANCES NO	ATH (ITEM 27)	(Type, Print)	hann	& Ona	2_		1		
		MAR 1 4 1995 Jal	32. REGISTAR'S SID	ATURE			1100					

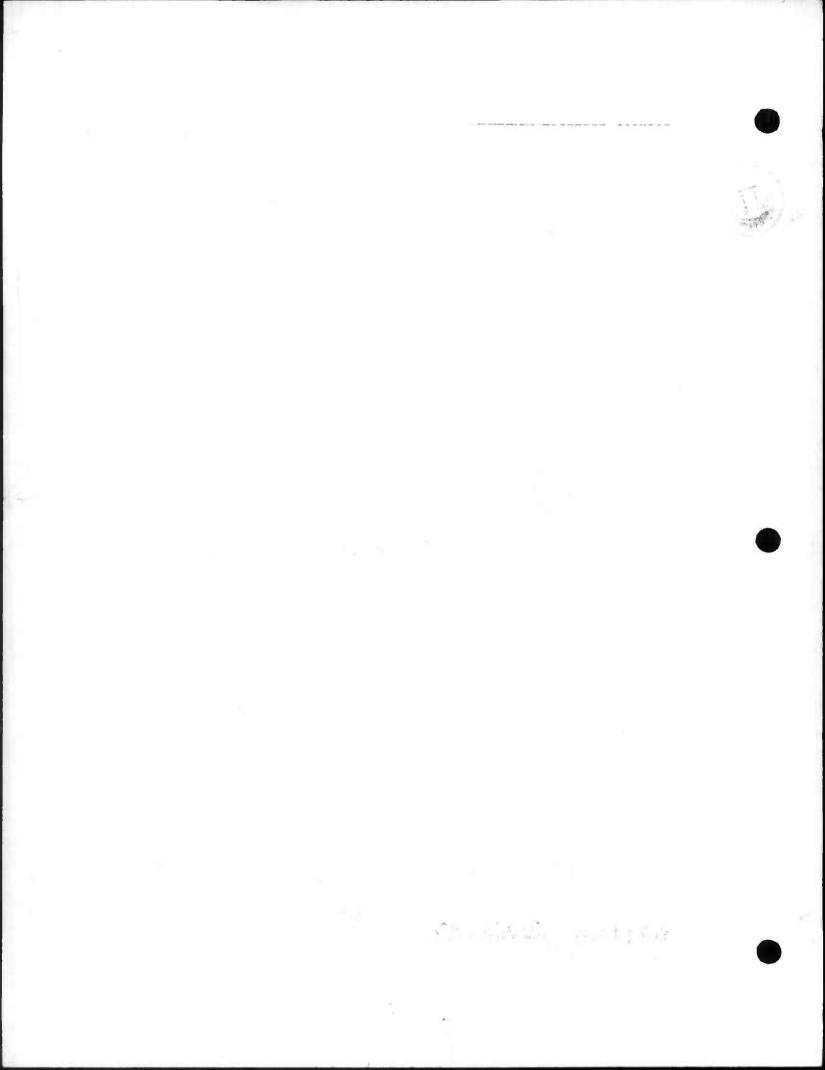
		2	dia a	
	BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician,	led in by the funeral director, page 5 should be detached for use as the burial-transit permi, or removal.	medical examiner must be notified at once.
72	DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permote filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CTATE OF MARY AND A DEDAG

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	REGISTRAR		CERTIF	-ICATE	OF DEATH	REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last)	VIRGIL FRAN	KLIN GARDNER			2. DATE OF DEATH		3. TIME OF DEATH		
	Virgill Frankli	GARDNER				March 7 1995 1.40D				
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday)	IF UNDER 1 Y	AR IF UNDER 24 HRS.	7 DATE OF BIRTH	4 8	1 • A D M		
	232-46-6184	1X(X) M 2 □ F	63 YRS.	MONTHS D	NYS HOURS MIN.	April 9, 1	931 10	est Virginia		
	9a. FACILITY NAME (If not institution, give s	street and number)		9b. CITY. TO	WN OR LOCATION OF		9c. COUNTY			
œ		,				LAIN	1			
5	Poctors Hospital Lanham Prince (
Æ	10a, STATE 10b. COUNT	Y	10c, CI	TY, TOWN OR L	OCATION			10d. INSIDE CITY		
Doctors Hospital RESIDENCE OF DECEDENT 100. STATE 1								1 Yes 2 No		
								OF WHAT COUNTRY?		
Ä	1109 Montrose Ave	MILO			20707			USA		
Ž	11. MARITAL STATUS	12. WAS DECEDENT EV	So In II o Agrees							
	1 Never Married 2 Married	FORCES? 1VV	YES 2 NO	If ye	s, specify Cuban, Maxis		s or No— 14, 1	RACE — American Indian, Black, White, atc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WATE	OR DATES	10	YES 2 NO Spec	ffy:	1	spoom: White		
	15. DECEDENT'S EDU	CATION	184, DECEDENT'S	I HEHAL OCCU	DATION					
E	(Specify only highest grade	completed)		work done durir	g most of working	166. KIND OF BU	SINESS/INDUSTI	ty .		
7	Elementary/Secondary (0-12)	College (1-4 or 5 +)			Engineer	A/	ASA			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	4	Lieu	mem						
						AME (First, Middle, Maiden	Sumame)			
BE	Virgil Gardner 19a. INFORMANT'S NAME (Type/Print)					chmertzler				
2						Route Number, City or Tox				
	V. Scott Gardner		12332	Sandi	i Point Co	urt, Belts	ville,	MD 20705		
	20a. METHOD OF DISPOSITION 1√2 Burlal 2 ☐ Cremetion 3 ☐ Ram	oval from State	20b. PLACE AND DATE cametery, crematory or	ther olered			CATION - City of			
	1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)		Gate of He	eaven (Cemeteru	13/10 Si	lver Sp	ring, Maryland		
1	21. SIGNATURE OF FUNERAL SERVICE EX	SENSEE		22. NAN	E AND ADDRESS OF F	ACILITY FROCK	Funeral	Home, Inc.		
	1 5/200	a) (bath	۸.	760	11 Sandu S	nrina Road	Laure	P. MD 20707		
	7601 Sandy Spring Road, Laurel, MD 20707 23. PART I. Enter the diseases, or promplications the leavest the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate									
	shock, or heart fallure.	List only one cause of	each line.	not enter the	moda or dying, au	on as cerdiac or reap	iratory arreat,	Approximata Interval Between		
	IMMEDIATE CAUSE (Final									
	disease or condition resulting in death)	porterior	autorias	Porat	in naudin	iaroulan di	10010	110.01		
Ì		DOE TO TON	AS A CONSEQUENCE	Price Con	u cruso.	MOCHEUT IN	361136	years		
Z	Sequentially list conditions,	b								
CERTIFICATION	If any, leading to immediate	DUE TO (OR	AS A CONSEQUENCE O	F):				10.07		
2	CAUSE (Disease or Injury	c								
胃	that initiated events resulting in death) LAST	DUE TO (OR .	AS A CONSEQUENCE O	F):				49 0		
8	Total III Godin CAST	d								
	PART II. Other significent condition	a contributing to dee	th but not requiting	In the under	lying cause given is	Part I. 24s. WAS AN	AUTODON			
EDICAL			an out not resulting	iii tile diluci	lying cause given ii	PERFOI		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
ă						1 _ YES :	NO	OF DEATH?		
×						_ /		1 YES 2 NO		
ž.	DID TOBACCO USE CONTI	RIBUTE TO CAUSI	OF DEATH Y	ES 🗌 NO	☐ UNCERTA	N 🗹				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	11000	26. PLACE OF DEA		one)	` _				
SI	1 TES 2 NO	HOSPITAL: 1 ☐ Inpetiant 2 ☐ ER/	Outpetient 3 - DOA	OTHER: 4 Nursing	Home 5 - Rasidence	8 Other (Specify)				
호	27. MANNER OF DEATH	28a. DATE OF INJU		E OF 28c	INJURY AT	28d. DESCRIBE HOW	NJURY OCCURE			
4	1 Netural 5 Pending	(Month, Day, Ye	er) IN	JURY M 1	WORK?			1		
> 1										
ВУ	2 Accident Investigation	28e. PLACE OF INJ	URY — At home, farm,	street, factory,	Offica	28t, LOCATION (Street)	and Number or Ru	rel Bruste Number		
		28e. PLACE OF INJ building, atc. (URY — At home, farm, Specify)	street, factory,	OTTICA	281. LOCATION (Street City or Town, Stete)	and Number or Ru	rel Route Number,		
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	bollding, atc.	эреспу) 			City or Town, State		rai Route Number,		
	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only	CIAN: To the best of my k	nowledga, death occum	ed at the time,	data and place, end du	City or Town, State,	nner as stated.			
	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only	CIAN: To the best of my k	nowledga, death occum	ed at the time,	data and place, end du	City or Town, State,	nner as stated.	rel Route Number,		
COMPLETED	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only	CIAN: To the best of my k	nowledga, death occum	ed at the time,	data and place, end du	o to the cause(e) end me	nner as stated.			
BE COMPLETED	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only 20 2 MEDICAL EXAMINE	CIAN: To the best of my k	nowledga, death occum	ed at the time,	data and place, end du	o to the cause(e) end me	nner as stated.	ee(s) and manner as stated.		
COMPLETED	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only 20 2 MEDICAL EXAMINE	CIAN: To the best of my k	nowledge, death occurrention and/or investigation	ed at the time, on, in my opinio	data and place, end du	o to the cause(e) end me	nner as stated.	ee(s) and manner as stated.		
BE COMPLETED	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER THUMBER 2 Could not be determined 8 Could not be determined 8 CERTIFYING PHYSI 2 MEDICAL EXAMINE	CIAN: To the best of my k	nowledge, death occurrention and/or investigation	ed at the time, on, in my opinio	data and place, end du	o to the cause(e) end me	nner as stated.	ee(s) and manner as stated.		
BE COMPLETED	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER THUMBER 2 Could not be determined 8 Could not be determined 8 CERTIFYING PHYSI 2 MEDICAL EXAMINE	CIAN: To the best of my k	nowledge, death occurrention and/or investigation	ed at the time, on, in my opinio	data and place, end du	o to the cause(e) end me	nner as stated.	ee(s) and manner as stated.		

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hours after death. Page 6 may be retained by the hospital or attending physician. lied in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 i, or removal.	medical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	O BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ERNESTO

											9	5 (07616	
	for STATE REGISTRAR		STATE OF MA					EALTH AND DEATH	MEN	ITAL HYGIEN	_			
		BERT	- JUSEPH	G	4176	_	GER	RITY		DATE OF DEATH ONTH D	13	YEAR 95	3. TIME OF DEATH 4:30 M	
	4. SOCIAL SECURITY NUMB N/A	BER	5. SEX	8. AGE (In yrs. les	t birthday)	MONT!	HS DAYS	IF UNDER 24 HRS. HOURS MIN.		ATE OF BIRTH Month, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign y)	
	9a. FACILITY NAME (If not in	and the state of the state of	41		3 11 31 MAR. 9, 1995 [Mary			
DIRECTOR	University	of Mai		spital	,						9c. COU	9c. COUNTY OF DEATH N/A		
E C	10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOW	N OR LOCAT	ION				-	10d. INSIDE CITY	
	Maryland		N/A		Ba:	Baltimore City							LIMITS?	
A	10e. STREET AND NUMBER		101. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?						
D BY FUNERAL	1341 Walker Avenue				21239			U.S.			Α.			
	11. MARITAL STATUS 1X Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				NO If yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, atc. 1 YES 2 NO Specify: Specify:						t, White, etc.			
COMPLETED		EDENT'S EDU- y highest grade (-12)		(G	(Give kind of work done during most of working life. Do NOT use retired.) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)									
SO	17. FATHER'S NAME (First, M.									rst, Middle, Maiden				
BE	David John		ty							e Guis				
5	Nina Lee Ge							venue, B					21239	
	20a. METHOD OF DISPOSITI 1 Burlal 2 Crematio 4 Donation 8 Other	n 3 🗆 Rame (Specify)		20b. PLACE A cemetery, cre Dulane	metory or o	of DISI	POSITION (Na ce) ey	me of MAR				city or To	wn, State Maryland	
Mit								nell-Wie York Rd	def	eld Home	e e, Ma	aryla		

IN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. ORRUTATION OF AOQTA DUE TO (OR AS A CONSEQUENCE OF): CHRONOSONAL DECETION DUE TO (OR AS A CONSEQUENCE OF): d.										
	PART II. Other algnificant condition	PERFO	N AUTOPSY DRMED? 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 UYES 2 NO							
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	8 Other (Specify)									
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28c. INJURY AT WORK?	28d. DESCRIBE HOW	DESCRIBE HOW INJURY OCCURED						
ED	3 Suicide 8 Could not be 4 Homicide determined	281, LOCATION (Street City or Town, State	OCATION (Street and Number or Rural Route Number, Dity or Town, State)								
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(a) and manner as stated.										
TO BE	200. SIGNATURE AND ATTLE OF CERTIFIES	IMBER	29d. DATE S	HIGNED (Month, Day, Year)							

ST.

SOUTH GREENE

COARUTATION

31. DATE FILED (Month, Day, Year)

6.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ONG

DHMH-16 Ray 1/89

2/20/

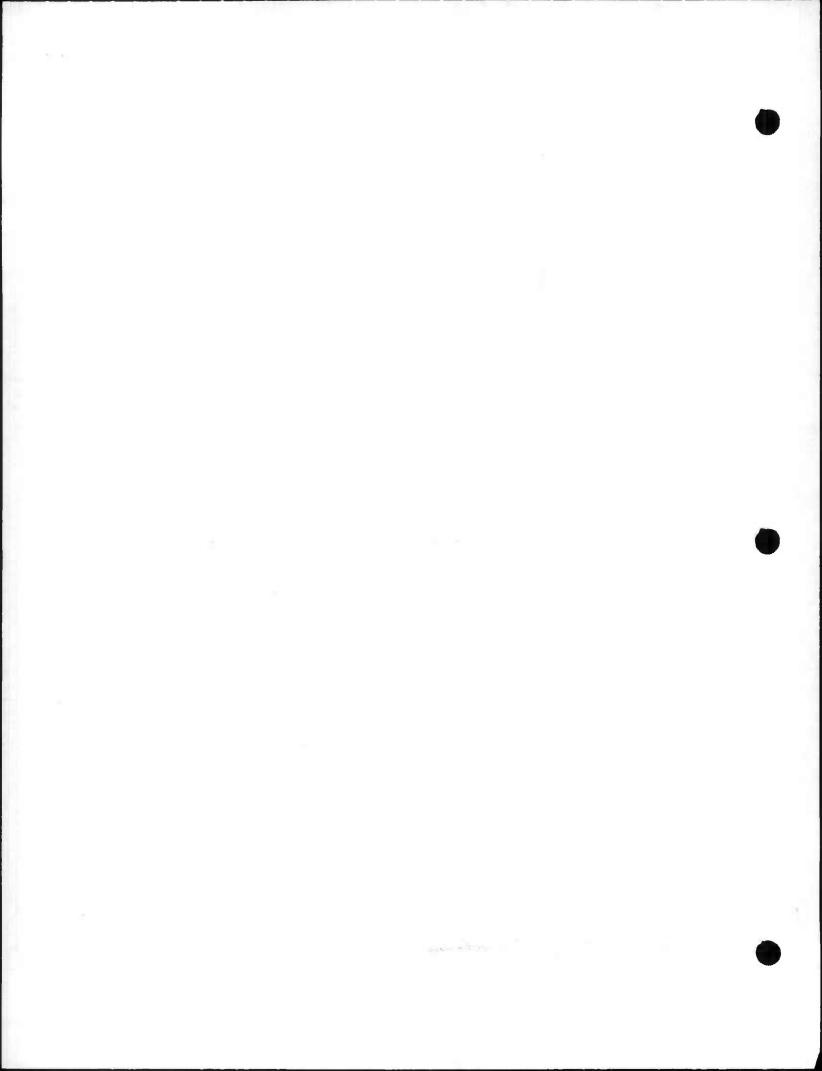
BALTIMORE MD

, i

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

	REGISTRAR			ERIIF	ICALE	OF	DEATH		REG. NO					
	1. DECEDENT'S HAME (First, Middle,							2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DEATH		
	ROSE 4. SOCIAL SECURITY NUMBER	Giordano						Mar			995	7:30 A M		
	053-05-2489	5. SEX	8. AGE (In yrs. In		IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS M/N.	7. DAT	e of BIRTH rith, Day, Year) Y 3, 19	10	8. BIRTHE	PLACE (State or Foreign		
	9a. FACILITY NAME (If not institution,		/3	THS.	AL AITH	-			y 3, 19			Italy		
Œ	6518 River Cly	de Drive			96. CITY, TOWN OR LOCATION OF DEATH N/A HOWard					_				
18	RESIDENCE OF DECEDEN					1	V/ A			110	Jwar	4		
DIRECTOR	10a. STATE 10b. Co			10c. CIT	Y, TOWN OF		TION					10d, IHSIDE CITY LIMITS?		
	MD 10e, STREET AHD HUMBER	Howard				I/A						1 YES 2 NHO		
RA	6518 River Clyc	e Drive			10f. ZIP CODE 20777					10g. CITIZ	USA	HAT COUHTRY?		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IH U.S. A	U.S. ARMED 13. WAS DECENOEHT OF HISPANIC ORIGINS OF					IN2 (Specify Voc	or No.		- American Indian,		
	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 X	НО	11	yes, sp	ecity Cuban, Maxi	can, Puarte	Pican, atc.)	or no-	Black,	White, atc.		
ВУ	3 Widowed 4 Divorced						- I Miles ope	ony.			Specify	White		
COMPLETED	15. DECEDENT'S (Specify only highest		16a. D	Give kind of	CEDENT'S USUAL OCCUPATION 16b. KIHD OF BUSINESS/I 16b. KIHD OF BUSINE						JSTRY			
P.E.	Elementary/Secondary (0-12)	College (1-4 or 5 +)	memak					Own I	Iomo				
OM	17. FATHER'S NAME (First, Middle, Las		110	incinas			18. MOTHER'S I	IAME (First	, Middle, Maiden					
ш	Gaetano Nicole	ella					Lucrez		Molinar					
TO B	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											_		
-	Ralph Giordano (Spouse) 6518 River Clyde Dr., Highland, MD 20777													
	20a, METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3	Removal from State	20b. PLACE cemetery, c	ematory or o	of DISPOSIT	IOH (Na	ame of	DA	TE 20c. LO	CATION - C	Ity or Tow	n, State		
	1 M Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF NERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Home													
	Услене	1 30	S.		Ler	.ОУ	M & Rus	sell						
	23. PART I. Enter the diseases	X	7	t set B	555	5 1	Win Kno	lls	Rd. Col	umbia	a, MI	21045		
TION	IMMEDIATE CAUSE (Finel disease or condition reculting in deeth) Sequentielly liet conditions, if any, leading to immediate	ь	OR AS A CONSI	EOUENCE OI	·):	م	n Ce	رف	to L	ive	/	Interval Batween Onset and Death / year ,		
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d													
	PART II. Other significent cond	fitions contributing to	deeth but not	resulting i	n the und	erlying	g cause given i	n Part I.	24a. WAS AH			WERE AUTOPSY FINDINGS		
EDICAL	PERFORMED? AMALABLE PRIO 1 YES NO OCOMPLETION OF DEATHY										COMPLETION OF CAUSE OF DEATH?			
ME												T YES 2 NO		
AN	DID TOBACCO USE CO			ATH YE			UNCERTA	IN 🗆						
i i	EXAMINER? 1 YES 2 HO	HOSPITAL:			OTHER:									
PHYSICIAN: M	27. MAHHER OF OEATH	28a. DATE OF	IHJURY	28b. TIM	E OF 2	ec. INJ	Residence	1	er (Specify) SCRIBE HOW II	JURY OCCI	UREO			
ВУ Р	1 Nstural 5 Pending 2 Accident Investiga	(Month, Da	ty, Year)	INJ	URY M		PRK? YES 2 HO							
	3 Suicide e Could no	28s. PLACE Of building.	F IHJURY — At h	ome, farm, s	treet, factor	y, offici			CATION (Street a	nd Number o	or Rural Ro	ute Number,		
E	4 Homicide determin	od .							, or lown, otero,					
COMPLET		PHYSICIAN: To the best of												
Š	2 MEOICAL EXA	MINER: On the beals of an	amination and/or	Investigatio	n, in my opi	nion, de	eath occured at th	e time, del	and place, and	due to the	cause(a)	and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CER	TIFIER	W 3			\neg	29c. LICENSE N	JMBER		29d. DATE	SIGNEO (Month, Day, Year)		
2	<u> </u>	700	VO D	•			1411	3 7		▶ 3	//3	195		
-	30. NAME AND ADDRESS OF PERSON	THO COMPLETED CAUS	OF DEATH (ITI	EM 27) (Type	Print)	سا	a (9.	ے أط	1.	0	21044		
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	A'S SIGHATURE	,			1	- U	ے ا ماہ	~~				
	MAR 1 4 1995	Jalin Studies	Redell				U							
									_			OHMH-16 Rev 1/89		



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IN THE FUNCKAL UNICATE WIS CENTIFICATE HAS DEED SIGNED BY THE ATTENDING PRYSTORIAN AND COMPRESSY THE PUNCKAL UNICATE HAS SHOULD BE DESTRUCTED BY THE BUTTALFARANSIT PERMIT, Pages 1, 2, 3 Should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burtal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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	Item5 3-14-95	FilmG/21	W.H.Per	r F/H					9!	5 07	618					
	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND / I	DEPARTME	NT OF H	EALTH AN	D MENTA			,						
	1. DECEDENT'S NAME (First, Middle, Last)		CE	RTIFICA	IE OF	DEATH	0.0475	OF DEATH		1						
	MERLE FRANKLIN	HYMILLER					MONT		~ 1995	YEAR	ME OF DEATH					
	212-14-5922	1 M 2 X F	AGE (In yrs. last I	YRS. IF U	HS DAYS	IF UNDER 24 HR	s. 7. DATE (Month)	OF BIRTH	921	8. BIRTHPLAC Spuntry) Maryl	E (State or Foreign and					
Œ	90. FACILITY NAME (If not institution, give street 435 N. Clinton St				Baltin	OR LOCATION OF			9c. COUNTY OF DEATH							
DIRECTOR	RESIDENCE OF DECEDENT			- '	Juni	10/LE			IV/	A						
l Ä	10e. STATE 10b. COUNTY			10c. CITY, TOW		ION			10d.	INSIDE CITY						
	Maryland N/A			Balt	imore	. ZIP CODE			10- 017	1 🖔	YES 2 NO					
FUNERAL	435 N. Clinton S				21224					S.A.	COUNTRY?					
BY FUR	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT, E FORCES? 1 [X] IF YES, GIVE WAR WO'LD	YES 2 NO OR DATES	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify V It yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:						pa or No— 14. RACE — American Indien, Black, White, atc. Specify: White						
8	15. DECEDENT'S EDUCAT	TION		e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working							mue_					
LETI	(Specify only highest grade co	conpleted) College (1-4 or 5 +)	Me. D	Oo NOT use retire	ed.)	st of working										
COMPLET	12th Mechanic Baltimore City Fire 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme)															
BE	Milton Roscoe Hymiller Edna Polk Myers 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)															
2	19a. INFORMANT'S NAME (Typo/Print) Catherine Hymille	- 16027aV														
						on St.,										
	20a_METHOD OF DISPOSITION 1	si from/State	Cemetery Creme	DATE OF DISI	Position (Na Emori	me ot al Grdv	us. 3/14	20c. LO	cation — altir	none. M	aryland					
	21. SIGNATURE OF FUNERAL SERVICE LICEN	NSEE			22. NAME AN Schumi	ID ADDRESS OF UNER FL	FACILITY	Home								
_	22 PART From the diseases or of	Jeine			3331	Brehms	Lane,	Balti	more,	Md.	21213					
	23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. Ust only one cause on each line. Approximate interval Between															
	disease or condition resulting in death) a. Just To (OR AS A CONSECUENCE OF):															
	DUE TO (OR AS A CONSECUTAÇÃE OF):															
ERTIFICATION	Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):															
CAI	cause. Enter UNDERLYING CAUSE (Disease or injury															
TIF	that initiated events resulting in death) LAST	DUE TO (OF	R AS A CONSEQU	ENCE OF):												
CEF	d															
MEDICAL	PART ii. Other algnificant conditions	contributing to de	ath but not res	suiting in the	underlying	cause given	in Part i.	24a. WAS AN	MED?	AMIL	AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE					
원					/		_	1 YES 2	NO	OF DE	EATH?					
Z	DID TOBACCO USE CONTRIB	BUTE TO CAUS	SE OF DEATH	H YES	NO 🗆	UNCERTA	AIN 🗆			, ,,	YES 2 NO					
PHYSICIAN:		HOSPITAL:		OF DEATH (Che	IER:											
HYS	27. MANNER OF DEATH	28s. DATE OF INJ	JURY	28b. TIME OF	Nursing Home 28c, INJL	5 Reelden	7	(Specify) CRIBE HOW IN	UURY OCC	LIRED						
ВУ Р	1 Natural 5 Pending	(Month, Day,	Year)	INJURY	WOI					Jones						
	2 Accident investigation 3 Sulcide 6 Could not be determined determined determined									or Rural Route N	umber,					
	_ Could not be						29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(a) end manner as stated.									
LETED	4 Homicide determined	N: To the heat at	knowledge death	h negured of th	na Alexa des	and later to the	in a c	A. J. J. C. Julio		·.						
OMPLETED	4 Homicide determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA										nenner se stated.					
E COMPLETED	4 Homicide determined 29a. CERTIFIER (Check only)						the time, date		d due to the							

LETED CAUSE OF DEATH (ITEM 27) Pipe. Print)

— X

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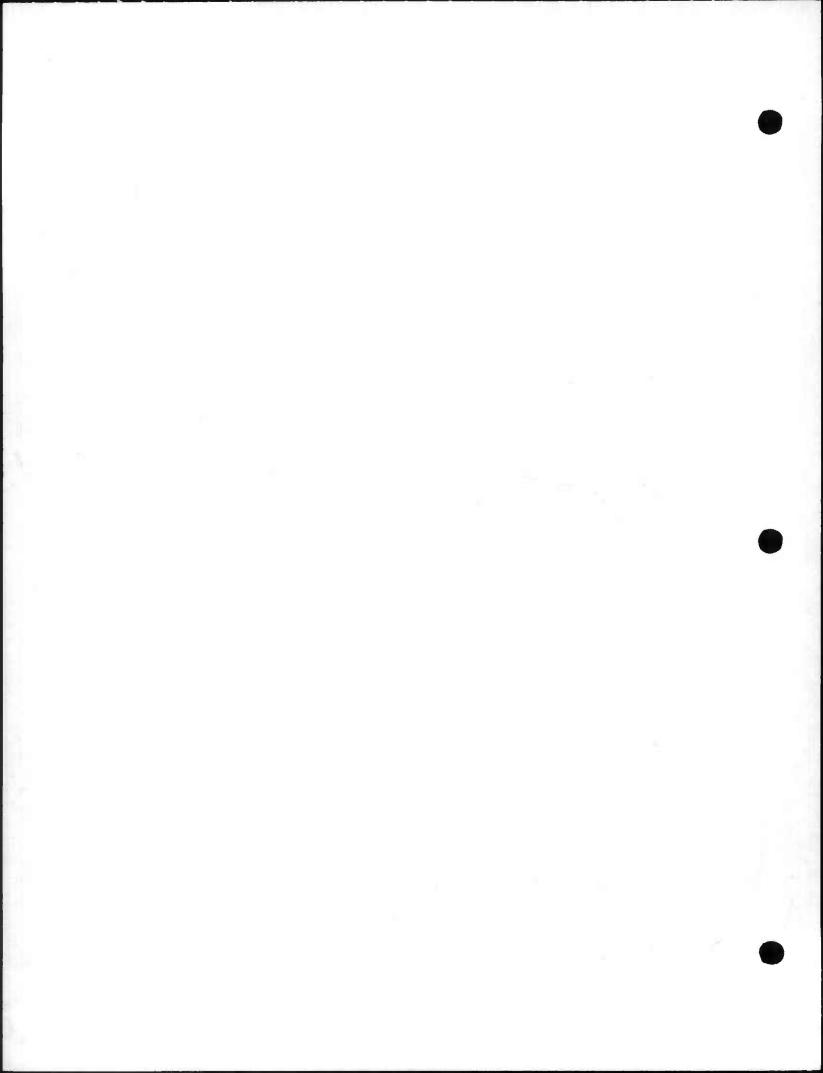
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	BLOSSIE GORDELIA		LY HUI	CHINSON		мдитн ви	1995	7A.M. M				
	Control of the Contro	5. SEX 6. AGE (In yrs. lat		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Cour	HPLACE (State or Foreign itry)				
	217-20-2783 9a. FACILITY NAME (If not institution, give stree	1 □ M 2 X F 67	YRS.			8-30-192		TIMORE,MD.				
Œ					R LOCATION OF DE	ATH	9c. COUNTY OF					
20	614 N. MT. MOUNT	SIKEEI		BALTIM	UKE		150 Hz	o. CHY				
DIRECTOR	10a. STATE 10b. COUNTY	11 01		TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?				
	MARYLAND STREET AND NUMBER	Mo. Goty	BAL	TIMORE	7IR COOF			14 YES 2 NO				
FUNERAL	614 N. MOUNT STRE	ET.		2.0	109. CITIZEN OF WHAT COUNTY USA							
S		12 WAS DECEDENT EVEN IN IL S. AS	RMED	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No								
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 VI	NO	If yes, spe	cify Cuban, Mexical 2 NO Specify	n, Puerto Rican, etc.)	Blac Spe	ck, White, atc.				
	15. DECEDENT'S EDUCAT	TION LIES OF	ECEDENTIA II	SUAL OCCUPATIO				F.AMERICAN				
COMPLETED	(Specify only highest grade co	INESS/INDUSTRY										
됩	12	Culular										
00	17. FATHER'S NAME (First, Middle, Last)	Surname)										
BE	ERNEST BURTWELL				NOLA	JONES						
2	196. INFORMANT'S NAME (Type/Print) 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET BURTWELL 130 AISQUITH STREET APT-A BALTIMORE, MARYLAND											
	20a. METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of											
	1 Burial 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Special 2 Charles of Control 2 Charles of Cha											
	21. SIGNATURE OF FUHERAL SERVICE LICEN	ISES /		22, NAME AN	BROTHERS	FUNERAL H	IOME, P. A.					
	My My	Oller		1300 E	UTAW PLA	CE, BALTIM	ORE, MD.					
	23. PART I. Enter the diseases, or con shock or heart failure. Lie	mplications that caused the de st only one cause on each line	eth. Do no	t enter the mod	de of dying, auch	as cerdiec or reapir	retory arrest,	Approximate				
	HAMPOLATE CALLOE (EL.)			1 - (=	- /	• _		Interval Between Onset and Death				
l	resulting in death) a. Acate Myocardial Intorction (1 hr.											
z		Severe Co	2 / MO	iva A.	Hery T	Diseale		V- months				
CERTIFICATION	disease or condition a. Acade Myocardial Infortion a. Acade Myocardial Infortion DUE TO (OR AS A CONSCOUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF):											
2	cause. Enter UNDERLYING CAUSE (Disease or injury											
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST											
	DART II Other classificant conditions											
CAL	PART II. Other algnificant conditions of	contributing to deeth but not i	reeulting in	the underlying	cause given in i	Pert I. 24s. WAS AN A PERFORI	1500	MERE AUTOPSY FINDINGS AMILABLE PRIOR TO				
ED						1 YE\$ 2	MO	OF DEATH?				
≥ ;	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF DEA	TH YES	ПОП	UNCERTAIN	TIP		1 YES 2 NO				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH	(Check only one)								
YSI	1 Nes 2 No 1	☐ Inpatient 2 ☐ ER/Outpatient 3		OTHER: Nursing Home	5 Maaidenca	8 Other (Specify)						
	27. MANNER OF DEATH 1 → Natural 5 → Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WOF	RK?	26d. DEŞCRIBE HOW IN	JURY OCCURED					
BY	2 Accident Investigation	28s. PLACE OF INJURY — At ho	ome, farm, str		ES 2 NO	281. LOCATION (Street ar	nd Alumbar as Fluid	Courte Number				
COMPLETED	4 Homicide 6 Could not be determined	building, atc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	out, factory, office		City or Town, State)	nd Number of Hurai	Houte Number,				
PE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	IN: To the best of my knowledge, de	eth occurred	at the time, date of	and place, and due	to the cause(s) and mann	ner as stated.					
ĕ O	298. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated.											
BE	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Mpnth, Day, Man)											
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
-	DAVID B. ALE	CCO 22 (M 27) (Typo, P S . G	REEW	EST.	BALTO	mi)	21201				
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE						-				
	31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE MAR 1 4 1995 Julia d'hurdien-hardall											



Pages 1, 2, 3 should

permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transft be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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MAYAM

31, DATE FILEO (Month, Day,

95 07620 Item # 1 Film # G 721 3-14 Film # G 721 3-14=95 N.A. Per funeral home 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH RUTH Sause YEAR HARRIS 2.35 AM MARCH 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR 7. DATE OF B 7. DATE OF BIRTH April 1281, 1923 71 218-12-7941 DAYS HOURS 1 - M 2 X Barto. Md. YRS 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore City Good Samaritan Hospital RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Baltimore Co. Maryland 1 YES 2 NO FUNERAL 10a, STREET AND NUMBER 109. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 21234 10103 TIPPERARY ROAD 12. WAS DECEOENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puario Rican, etc.) 1 — YES 2 NO Specify: RACE — American Indian, Black, White, etc. Specify: White FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married B 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 18b. KINO OF BUSINESS/INOUSTRY (Give kind of work done life. Do NOT use retired.) College (1-4 or 8 +) ntary/Secondary (0-12) 11 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malde, Surname)
Mary Elizabeth Gunkel Carl Peter Sause 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Lawrence Harris, Sr. 10103 Tipperary Rd. Baltimore.Md. 21234 20a METHOD OF DISPOSITION
1 DABurlat 2 Crematton 3 Ramovat from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, Stata Parkwood Cemetery 4 Donation 5 Other (Specify) 3-16-95 Parkville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <mark>ቸረመሴ ተምማ፣ የመሮ</mark>ዚ Funeral Home Inc. 5305 Harford, Rd. Baltimore, Md. Lic.# M00677 Harford, Rd. Baltimore, Md. 21214 Lenter the dispases, or compleations that caused the data shock, or heart failure. List only one cause on each line. ses, or complyations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition SEPSIS resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CARCINOMA OF PANCREAS COMPLETION OF CAUSE 1 YES 2 NAO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Dinpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 THE 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF GEATH 28e. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

M.D

9000

32. DEGISTRAR'S SIGNATURE

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

GU

P08236

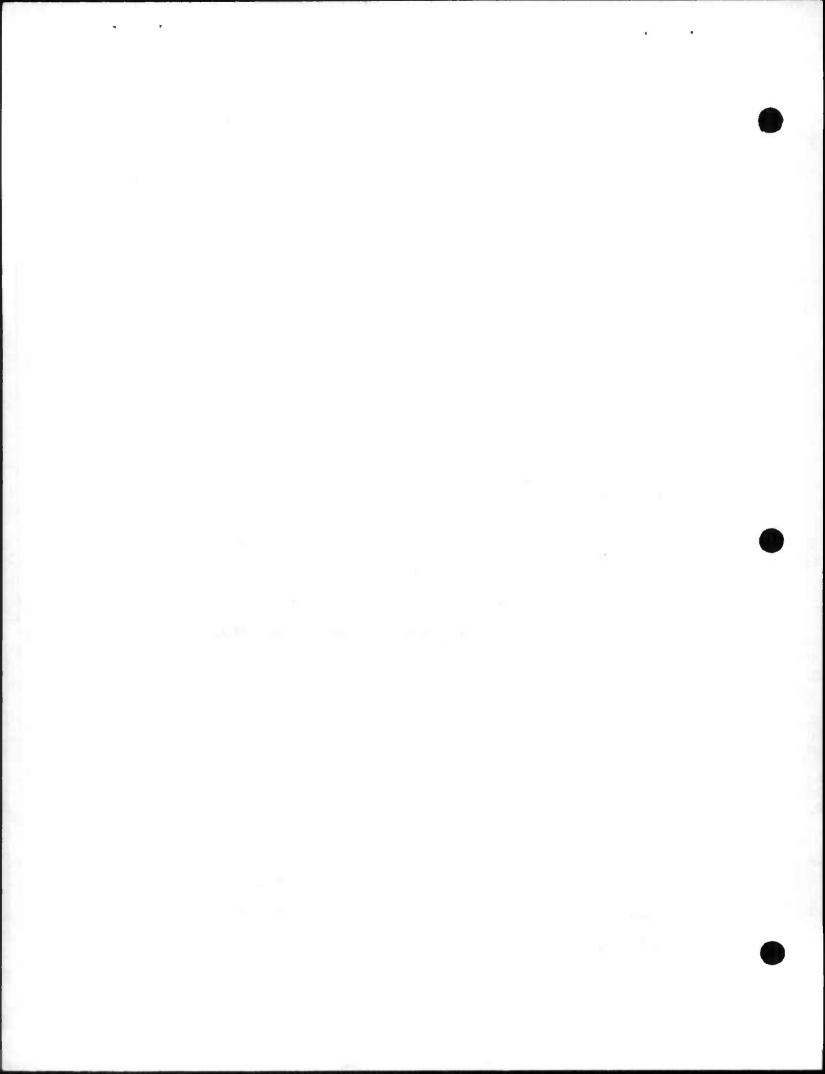
BAMARI TAN

DHMH-16 Rev 1/89

HOSP I TAL

1995

_		FOR STATE REGISTRAR	STATE OF MARYLA	AND /	DEPARTMEN	T OF H	EALTH AND	MENT	AL HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last) MILLARD	RAYMOND	ŀ	HALE S	SR.		2. DAT	Var 11	995	YEAR	6:20 pm
		4. SOCIAL SECURITY NUMBER 219-26-1032	5. SEX 8. AGE (H	n yrs. last	YRS. MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	Nov	E OF BIRTH nth, Day, Year) 7 • 16 • 19		8. BIRTHP Country) MARY	
act	2	9a. FACILITY NAME (If not Institution, give s Saint Joseph Medic RESIDENCE OF DECEDENT					on Location of D			9c. COUN Ba	TY OF DEA	ATH B
AI DIBECTOR	DINEC	10s. STATE 10b. COUNTY	TIMORE		10c. CITY, TOWN UPPER		TION				- 1	IOd. INSIDE CITY LIMITS?
FINEDAL	FINAL	100. STREET AND NUMBER 17200 Fal	ls Rd.			101	2115	5.5		10g. CITIZ	EN OF WH	AT COUNTRY?
2	5	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR DA Apr. 3,1951-0	2 N	0	If yes, sp	ENDENT OF HISPA ecity Cuban, Mexic 2 XIO Speci	NIC ORIG	IN? (Specify Yea Rican, etc.)	or No-	14. RACE -	- American Indian, Whita, atc.
ETED	1	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Gh	CEDENT'S USUAL Or kind of work done Do NOT use retired.	during mo	ON st of working	16	b. KIND OF BUS	INESS/INDU	STRY	
once.	-	12 17. FATHER'S NAME (First, Middle, Last)	4 (Chie:	f Meteor	olog		Education AME (First, Middle, Melden Surmame)				
16 L	: -	George 19a. INFORMANT'S NAME (Type/Print)	Millard Hale						Burk		-	
be notified	IJ-	Mrs. Louise W. H										
must		20e. METHOD OF DISPOSITION 1 Duriel 2 Cremetton 2 4 Donation	Me State	tary, cren	nd DATE OF DISPO natory or other place Cremato	ry,	Inc.	۹۸ MAI	3 1	onsvi		•
val.		21 SIGNATURE OF PUMERAY SERVICE CO	Lemmon	K:		Lem 10	mon Fune W. Pador	eral nia H	Rd., Ti	moniu	m. M	D 21093
rent, the medical		23. PART r. Enter the diseases, or cahock, or heart feiture. If IMMEDIATE CAUSE (Finel disease or condition resulting in death)	complications that caused List only one cause on each	ch line.					rdlec or respir	ratory arre	at,	Approximate Interval Between Onset and Dea Galcaewa
(a		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): SEPSIS; CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): GASTRIC OUTLET OBSTRUCTION OF GASTRECTOMY DUE TO (OR AS A CONSEQUENCE OF):										
traur CAT												
. 0 111		thet initiated eventa resulting in death) LAST	EXTENSIVE A			SMA	ILL BOWE	L RE	SECTION	1		unknown
ws any Inju		PART II. Other significent conditions	contributing to death bu	t not re	suiting in the u	nderlying	cause given in	Part I.	24a. WAS AN / PERFOR	MED?	Ci	ERE AUTOPSY FINDING WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
23 short of the AN: M		DID TOBACCO USE CONTR					UNCERTAI	N 🗆			'	YES 2. NO
State item		EXAMINER?	HOSPITAL: 1 Dipetient 2 ER/Outpet		OF DEATH (Check	R:	5 🗆 Residence	6 🗆 Oth	er (Specify)			
P ked		27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJI WOI 1 Y		28d. DE	SCRIBE HOW IN	JURY OCCU	IRED	
E S C		3 Suicide 6 Could not be determined	28s. PLACE OF INJURY - building, etc. (Specify	At hom	e, farm, street, fac	tory, office		28f. LOC City	CATION (Street ar or Town, State)	nd Number o	r Rurel Rou	te Number,
Mithin 72 hours a TANT: It Item 2 COMPLET	2	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINER	CIAN: To the best of my knowled	dge, deat	h occurred at the t	lime, data opinion, da	and place, and dua	to the ca	use(a) and menr	ner as stated	l. cause(a) a	nd menner as stated,
2		296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI				SIGNED (M	onth, Day, Year)
2 2	3	90. NAME AND ADDRESS OF PERSON WHO				ows	D 24029 ON, MARY		21204		11:01	/)
`	13	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URE								
	بال	MHK 1 4 1995	THE PROPERTY OF	100								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State Deat, of Health and Mental Huniana nois in hurial cremation or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	ITEMS: 1. & 6. PER F.	H. FILM G-721	3/14/95 t.	t					95	07	622	
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMEN	T OF I	HEALTH AND	MENTA	L HYGIENI				
	1. DECEDENT'S NAME (First, Middle, Last)	Cher ELL	A C. HEFFN				MONT	OF DEATH	7.10	YEAR 3.	TIME OF DEATH	
	219078372	1 - M 2 0 F 72	(In yrs. lest birthdey)	MONTHS		IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont	OF BIRTH	923	Country)	ACE (State or Foreign ARYLAND	
TOR	96. FACILITY NAME (If not institution, give atres SINAI HOSPITAL RESIDENCE OF DECEMENT	of and number)			y, town ALTII	OR LOCATION OF D MORE	EATH			TY OF DEAT	Н	
DIRECTOR	10e. STATE 10b. COUNTY MARYLAND N/A			10c. CITY, TOWN OR LOCATION BALTIMORE						10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
AL	10e. STREET AND NUMBER				101. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	3309 DEVONSHIRE			21215						U.S	.A.	
В	11. MARITAL STATUS 1 Never Married 2 Married 3 XWIdowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 57 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: WHITE		
亞	15. DECEDENT'S EDUCA' (Specify only highest grade co	FION impleted)	16a. DECEDENT'S (Give kind of Ille. Do NOT u	USUAL C	OCCUPATI during me	ON ost of working	16b	KIND OF BUS	NESS/INDU	ISTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	RECEPT					STNAT	HOSDI	ጥልፕ.		
SON	17. FATHER'S NAME (First, Middle, Last)	111	KBCBI .	L LOIT.		18. MOTHER'S NA		SINAI HOSPITAL ME (First, Middle, Meiden Surneme)				
BE	WTI.I.TAM COHEN FANNY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Bural Route Number, City or									N		
2	MR. STEVEN HEFFNE	iR	4			RRI DR.,(
	20a. METHOD OF DISPOSITION 1X Buriel 2 Cremetion 3 Remove	206	PLACE AND DATE	OF DISPO	SITION (N		DAT	_		ity or Town,	State	
	4 Donation 5 Other (Specify)	B	ETH JACO	DB CC	ONG.		3/10/	<u>'95 F</u>	INKSE	BURG,	MD.	
	Neg 1	Their	ita	5	SOL I	ND ADDRESS OF FA LEVINSON REISTERS	& BE	a. da i	ΔΤ.ΤΩ	.MD.	21215	
	23. PART I. Enter the diseases, or complications that coused the death. Do not anter the mode of dying, such as cerdiac or reapire shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or constition resulting in death) But To (on As a consequence of):									et,	Approximata interval Between Onset and Death	
											Weeks Years	
RTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING										TEOWS	
ERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):								
O	PART II. Other algnificant conditions	contributing to death b	ut not resulting	in the u	nderlyin	g cause given in	Part I.	24a. WAS AN A	UTOPSY	24b. WE	RE AUTOPSY FINDINGS	
MEDICAL								PERFORM		CO	MPLETION OF CAUSE DEATH?	
ME	DID TOP ACCOUNT CONTROL	PLITE TO CALICE O	F DE ATIL M		VIO 19	C					YES 2 NO	
IAN	DID TOBACCO USE CONTRIS		P DEATH YE			UNCERTAIN	иПІ		-	1		
PHYSICIAN:	EXAMINER?	IOSPITAL: Inpetient 2 - ER/Outp	etlent 3 DOA	OTHE		e 5 🗆 Residence	6 🗆 Other	(Specify)				
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF IURY M		URY AT PRK?	28d. DES	CRIBE HOW IN	JURY OCCU	RED		
-	3 Suicide 5 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town,								d Number of	r Rurel Route	Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFVINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.											
BE	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUM	ABER .	т Т	29d DATE 9		gh, Day, Year)	
	AS 2402321 AG 9825								-	7/	1)	

32. REGISTRAN'S SIGNATURE

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

GUO Sindi He

exander

31. DATE FILED (Month, Day, Year)
WAR 1 4 1995

Baltimore

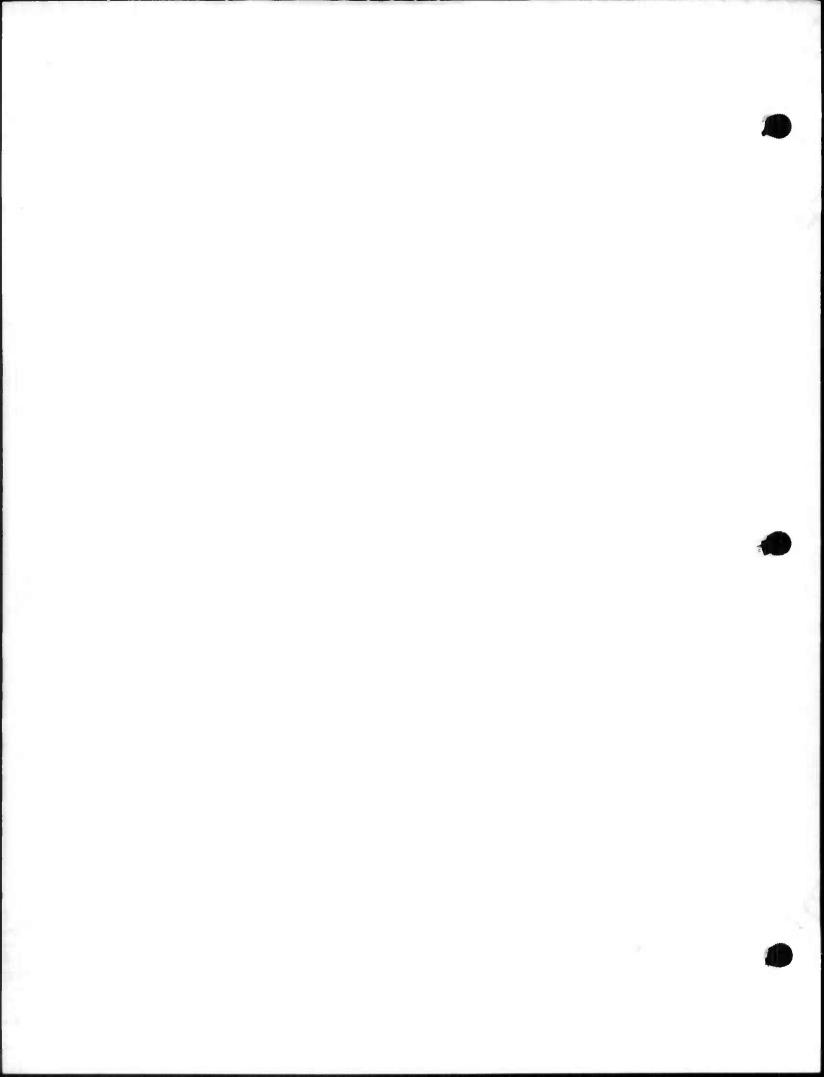
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

physician.	5 should be detached for use as the hurial transit nermit Dages 1 2 2 should	derive define porting 1 ages 1, 2, 3 should	
or attending	Wille as the		
y the hospital	be detached for		ed at once.
e retained or	e 5 should b		notified a
age o may be retain	ctor, page		nust be
Jr. Fage	eral direc		miner n
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Sinon	filled in b	in, or removal	e medi
cale be executed within a nous aller	an and completely filled in by the fur	crematio	vent, th
מצברתופת	and con	to burial,	matic e
Heale De	physician	ne prior 1	ner trau
ממון הפונו	ttending	tal Hygie	, or oth
at the oc	by the a	and Men	y injury
is. The law requires that the	his certificate has been signed by the	State Dept. of Health and Me	irked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifit
ME IGAN	has bee	e Dept. o	m 23 st
FILIDIOIDIE.	certificate	the State	, or iter
THE PHIL	fter this	eath with	marked
	IRECTOR: After thi	s after de	1 28 is
יוער מו עוודוו	RAL DIRE	72 hour	iff item
IN THE HOOLIN	THE FUNERAL DIRE	be filed within 72 hours after death with the SI	IMPORTANT: If Item 28 is marked,
2	2	pe #	MP

31. DATE FILED WARP

1995

											7	J	01023	
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	TMEN ICAT	T OF H	EALTH DEAT	AND I		GIENE				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DE	EATH			3. TIME OF DEATH	_
	Jessie Horn								March	9 ,]	1995	YEAR	5:35pm	М
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	t birthday)		R 1 YEAR	IF UNDER		7. DATE OF BIL	RTH		8. BIRTH	HPLACE (State or Foreign	_
	213-30-7167	1 ☐ M 2 1/2 F	86	YRS.	MONTHS	DAYS	HOURS	MIN.	May I	I,1908 Maryland			"yland	
	9e. FACILITY NAME (If not Institution, give str	eet end number)			9b. CIT	Y, TOWN O	R LOCATIO	ON OF DE	ATH		9c. COUNTY OF DEATH			
6	314 Riverside	Drive				Ess	ex					Ba1	Ltimore	ı
[[[[[[[[]	10a. STATE 10b. COUNTY			I soo CIT	V YOUND	00 1 0047	1041							
DIRECTOR	Md.	Balti	more	100.011	ry, town or location ESSEX								10d. INSIDE CITY LIMITS?	1
	10e. STREET AND NUMBER					101	ZIP CODE				40 - OIT!	7511 05 1	1 TYES K NO	_
8	314 Riverside I	Orive			21221						10g. CI 112		WHAT COUNTRY? JSA	
FUNERAL	11. MARITAL STATUS		T EVER IN U.S. ARI	ARMED 13. WAS DECENDENT OF HISPANIC ORIG						alfu Man a	- No.		E — American Indian.	
	1 Never Married 2 Merried	FORCES? 1 IF YES, GIVE W	YES 20 N	NO If yes, specify Cuben, Mexican, Puer 1 ☐ YES 2 → NO Specify:					n, Puerto Rican,	etc.)	140-	Black	k, While, etc.	
ВУ	3. Widowed 4 Divorced				TES 2 BY NO Specify:							Speci	White	-
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. DE0	CEDENT'S	S USUAL OCCUPATION 16b. KIND OF BU					OF BUSIN	IESS/IND	USTRY	WILLE	٦
<u>"</u>	Elementary/Secondary (0-12)	College (1-4 or 5 d) Ho.	Do NOT us	e retired.)		or working							
₹				Hous	ewi	fe				own	n ho	me		
	17. FATHER'S NAME (First, Middle, Lest)								ME (First, Middle,					
BE	Alexander Helstowski Vincenta == 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
2	Doris Culver												21221	
	20s. METHOD OF DISPOSITION							חדו			_		21221	4
	120 Burlel 2 Cremation 3 Removed	val from State	20b. PLACEA cemetery, cren	natory or or	her place!	,				20c. LOCA			1.712-36	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE A	HOLY	Rosa			eter D ADDRES		/13/9	b Ba	ilti	.mor	e MD.	4
	PTILL	. 10	11	1,					eral 1	HOme	of	Es	sex	
	1 serry	Cor	mell	4	Jac	0 M	200	A 170	Ra1	t i mc	ra	Md	21221	
	23. PART I. Enter the diseases, or semplications that caused the death to not enter the mode of dying, such as cerdiec or respiratory errect, shock, or heart failure. Liet only one cause on each line.													
- 1	iMMEDIATE CAUSE (Finel disease or condition resulting in death) e. Atheras claratic Car Lib Varalla Li Slap													
	resulting in death) -	416	4-05 C	La.	sh'	((er.	100	Jasa	La	9	Slo	به:	
_ 1	DUE TO (OR AS A CONSEQUENCE OF):													
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEQ	UENCE OF	3:									-
¥ I	cause. Enter UNDERLYING				,								ĺ	1
Ĕ	CAUSE (Disease or Injury that Initiated events	DUE TO	OR AS A CONSEO	UENCE OF	7:								1	\exists
	resulting in desth) LAST													ı
O	PART II. Other significant conditions	contribution to	do não base mas a	- 441 - 1										4
PHYSICIAN: MEDICAL	CIA O	abeter		ouiting i	n the ur	aeriying	cause g	Iven in I		MAS AN AU PERFORME		24b.	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	ı
		ander	10				<u> </u>		_ 10	YES 2 5	KHO		OF DEATH?	1
Σ									_				1 - YES 2 - 40	ı
AN	25. WAS CASE REFERRED TO MEDICAL													_
를 I	EXAMINER?	HOSPITAL:	21101FA	RI	OTHE	₹:	3/		ck only one)					4
ž	27. MANNER OF DEATH	26a, DATE OF		28b. TIM		alng Home 28c. INJU			Other (Spec		Im ooo	I IDED		4
	1 Netural 5 Pending	(Month, De		INJ	JRY M	WOF	RK?		28d. DEŞCRIBE	HOW INJU	JHY OCCI	URED		1
BÁ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	INJURY — A1 hom	ne, ferm, s	treet, fact				28f. LOCATION	Street and	Number	or Rurel B	Inute Number	4
E	4 Homicide determined building, etc. (Specify)										ı			
COMPLETED	29e. CERTIFIER (Check only	AN: To the best of	my knowledge des	th occurre	d at the	Ima data	and pleas	and door	o the sour : (-)	nd es		4		4
M	(Check only one) 2 MEDICAL EXAMINER:	On the basis of ex	emination end/or in	rvestigation	n, in my c	pinion, de	ath occurs	d at the !	me, date and al	na menne ece. end 4	ros sinte	G.) and manner on stated	1
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day Year)													
BE	Hunbert 1	- 12mm	11	1/			7)//	YOE NUM	2G /	2	9d. DATE	SIGNED	(Month, Day, Year)	
2	30. RAME AND ADDRESS OF PERSON WHO/COMPLETED CAUSE OF DEATH (TEM 27 (Tem 200))													



o	relificate the expected within course after death. Dans & may be retained by the bosoital or secondary
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DIVISION OF VITAL RECORDS, P.O.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, and ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CEF	RIIFICA	TE OF	DEATH		REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH						3. TIME OF DEATH				
	WARNER CECTL			GE			MON		10.1	995	
DIRECTOR	CHC		AGE (In yrs. last bi	rthday) IF U	OER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH	10,1	_	2 • 5 0 pm M
	578-22-1838	[XM2□F	70	YRS. MONT	HS DAYS	HOURS MIN.	(Mor	th, Day, Year)	004	Counti	v)
	9e. FACILITY NAME (If not institution, give stree	ot and number)	70	Ob. (NTV TOWN	OR LOCATION OF E	NOA	• 1,1			SPRINGS
							DEATH			JNTY OF D	
	CROFTON CONV.			CROFTON ANNE ARUND					RUNDEL		
	10a. STATE 10b. COUNTY		1	loc. CITY, TOV	/N OR LOCA	TION					10d. INSIDE CITY
<u>چ</u> ا	1475										LIMITS?
	MD ANNE A	<u>co.</u> 1	CROF							1 YES 2 NO	
A.				_	10	H. ZIP CODE	10g. CITIZEN OF				VHAT COUNTRY?
9		SONVILLE		ROAD 21114			USA				
FUNERAL	11. MARITAL STATUS 1	2. WAS DECEDENT EVEN FORCES? 1X 1	ER IN U.S. ARMEI	D	13. WAS DE	CENDENT OF HISPA	NIC ORIGI	N7 (Specify Ye	a or No-	14. RACE	- American Indien, c, White, etc.
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	o B washer a B process									WH	ITE
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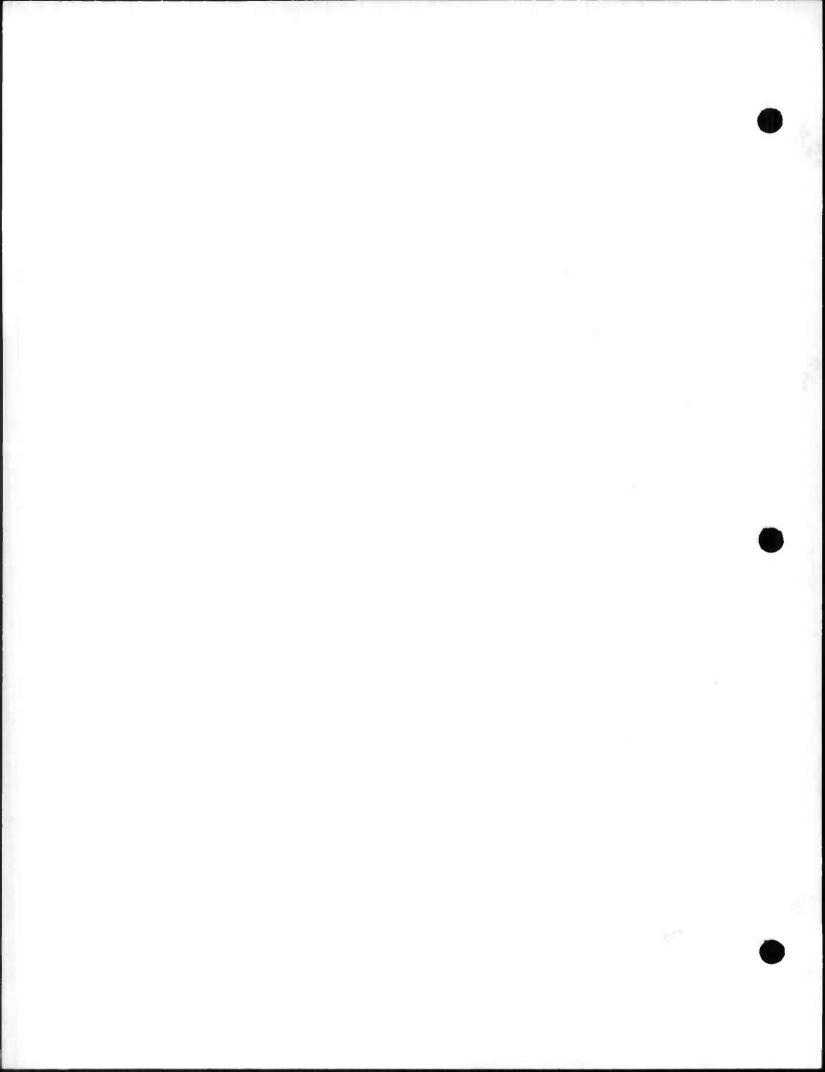
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95 07625 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR WADE HOUR MARCH 09. 1995 22:02 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign MONTHS DAYS 1 🔀 M 2 🗌 F HOURS 017-10-6825 YRS. 82 Sept. 5, 1912 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR UNIVERSITY SHOCK TRAUMA N/A BALTIMORE 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Howard Columbia 1 YES 2 NO FUNERAL 104 STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6827 Caravan Court 21044 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Merried 2 Merried ban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: ΒY Specify 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do_NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5 +) Steel Company Executive U.S. Steel 12 4 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) Elo W. Houk Dorothy Baldwin BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Wade B. Houk, Jr. (Son) 6827 Caravan Court, Columbia, MD 20s. METHOD OF DISPOSITION
1 Duriel 2 X Cremetion 3 Removal from State
4 Donetion 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Metro Crematory or other plece) Mar. 13,1995 Catonsville, MD 21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Home Cussellei 5555 Twin Knolls Rd. Columbia, MD 21045 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate Interval Between ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Atheroscleronic Cardioviscular resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2X ER/Outpatient 3 | DOA OTHER: 1 XYES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c, MJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner ee stated. 2X MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 46 MARCH 10,1995 OCME 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 DHMH-16 Rev 1/89



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DIVISION OF VITAL RECORDS,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mertial Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLANI		MENT OF		MEN1	AL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) Ellen 5.	Hughes				mo	TE OF DEATH DA	, 199	EAR 5	ME OF DEATH	
	219-10-1838	1 □ M 2 💢 F 69	: last birthday) YRS.	MONTHS DAYS	HOURS MIN	(Mi	onth, Day, Year)		BIRTNPLACE Country) Maryl	e (State or Foreign and	
TOR	9a. FACILITY NAME (If not institution, give stre Howard County Gen			96. CITY, TOWN OR LOCATION OF GEATH Columbia 90. COUNTY OF GEATH HOWARD							
DIRECTOR	10a STATE 10b. COUNTY MD HOWAY	UNTY 10c. CITY, T			TOWN OR LOCATION				10d. INSIDE CITY LIMITS?		
RAL	100. STREET AND NUMBER 11533 Shell Flower Lane			Columbia 101. ZIP CODE 21044					1 ☐ YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA		
BY FUNERAL		12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	X NO	If yes, s	CENDENT OF HISI	Ican, Puer	GIN? (Specify Yea to Ricen, etc.)	Yea or No- 14. RACE — American Indian.			
COMPLETED B	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION 18e ornpleted) College (1-4 or 5 +)	DECEDENT'S U (Give kind of wo life. Do NOT use	ISUAL OCCUPATI ork done during m retired.)	ON ost of working	1	6b. KIND OF BUS	INESS/INDUS	White	2	
MPL	12	2	Nurse	- RN			Healt	h Fiel	ld		
BE CO	17. FATHER'S NAME (First, Middle, Last) Irone E. Stevenso:	n			16. MOTHER'S Reba	G. G	t, Middle, Maiden ustin	Sumame)			
10	John P. M. Hughes		196. MAILING A	Shell F	nd Number or Rur Lower I	ane,	Columb	ia, State, Zip Co	i. 210	44	
	20a, METNOD OF DISPOSITION 1 X Burlai 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name of Maria OATE 20c. LOCATION — City or Town, State camelery, crematory or other place) AT LINGTON National Cem. 17, 1995 Arlington, Va.										
	21. SIGNATURE OF FUNERAL SERVICE LICE			Leroy	M & Ru Twin Kn	ssel	l C Wit	zke Fu	neral	Home	
	23. PART I. Enter tha diseases, or co- ehock, or heart feliure. Li IMMEDIATE CAUSE (Fine) disease or condition resulting in death)	Renal	ina. Fa	election of the modern of the second	ode of dying, a	uch ea c	erdiec or reepi	ratory arreal	,	Approximate interval Between Onset and Death	
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): CLISATION Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL C	PART II. Other aignificant conditions contributing to deeth but not reculting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 275-NO 24b. WERE AUTOPSY FI AMALABLE PRIOR COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION OF COMPLETION.						ABLE PRIOR TO LETION OF CAUSE				
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN W							YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OTHER: 1 Specified 2 FR/Outpetient 3 000 OTHER:										
Ě	27. MANNER OF DEATN	28s. OATE OF INJURY	28b, TIME	OF 28c. IN.	URY AT	_	her (Specify) ESCRIBE NOW IN	JURY OCCUR	ED		
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Dey, Year) INJURY WORK?									
	3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28a. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPLETED		AN: To the best of my knowledge On the basis of examination and							euse(a) and n	nenner as stated.	
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIED	Cary ?	mD		29c. LICENSE N	UMBER 33	3	29d. DATE SI	ENED (Month		
		pu's Farn	/	Zvad							
20	MAR 1 4 1895	32 REGISTRAR'S GNATUR	E								

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BALTIMORE, MARYLAND 21215-0020	pecuted within flours after death. Page 6 may be retained by the hospital or attending physi-
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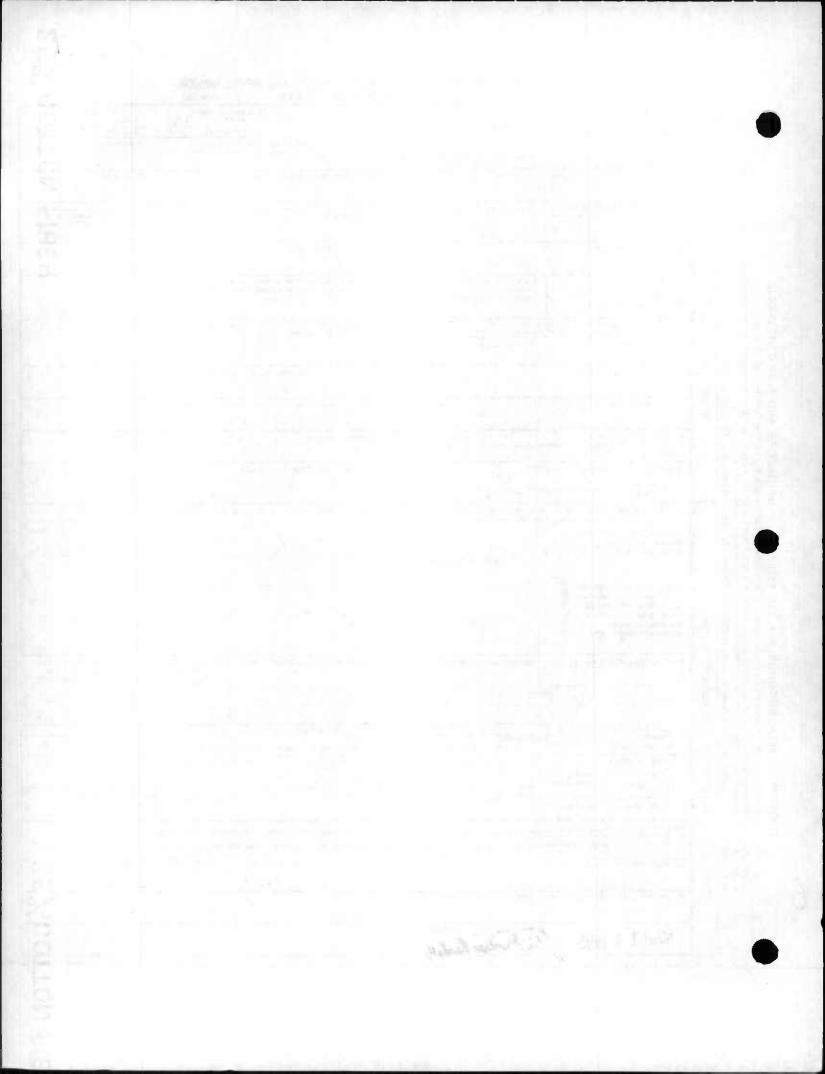
DIVISION OF VITAL RECORDS, P.O. BOX

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Abouts after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

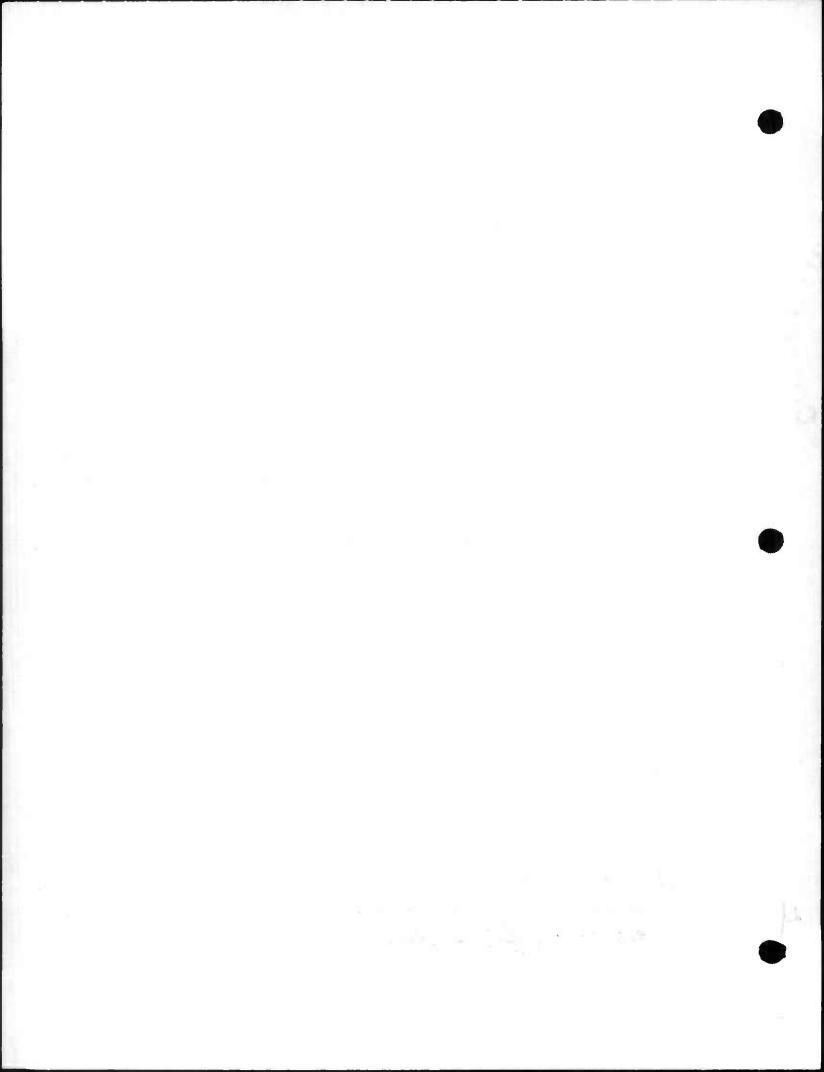
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REGISTRAR CERTIFICATE OF DEATH REG. NO.									
BY FUNERAL DIRECTOR	DOYOTHY	le le	MON			ATE OF DEATH DAY YEAR 3. TIME OF DE			
	135-01-1785	1 □ M 2 🂢 F			UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) June 22,	8.	BIRTNPLA Country) N.Y	CE (State or Foreign
	Lorien Nursing Home			b. CITY, TOWN OR I	EATN	9c. COUNTY OF DEATH HOWARD			
	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY 10e, CITY, TOWN OR LOCATION 10d IMPERE CITY								
	MD Howard			rown or location			1 [1. INSIDE CITY LIMITS? YES 2 X NO	
	12845 Folly Quarter Road				21042		10g. CITIZEN OF WHAT COUNTRY? USA		
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or If yea, specify Cuben, Mexican, Puerto Rican, atc.) 1 YES 2 NO Specify:				or No- 14. RACE — American Indian, Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S US (Give kind of wor life. Do NOT use i	BUAL OCCUPATION k done during most of ottred.)	f working	16b. KIND OF I	BUSINESS/INDUS	TRY	
MPL	12	N/A	Book Kee			Accou			
	17. FATNER'S NAME (First, Middle, Last) (Unknown)			1		AME (First, Middle, Meid known)	en Surname)		
BE	19a. INFORMANT'S NAME (Type/Print)		405 4444 440 44						
2	Robert Hearle	(Son)				Rd. Ellic			21042
	20e. METNOD OF DISPOSITION 1	noval from State Cerr	D. PLACE AND DATE OF netery, cremetory or othe etro Crema			DATE 20c.	LOCATION - City Catonsv		
	21. SIGNATURE OF FUNERAL SERVICE LI	1001	2	Leroy M	& Rus	sell C Wi	tzke Fu	nera]	l Home
	23. PART I. Enter the diseases, pr ahock, or heart failure.	complications that caused List only one cause on e	d the deeth. Do not ech line.						Approximata Interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ine has	t of	gila	É		Onaet end Death		
		DUE TO (OR AS A	CONSEQUENCE OF):						
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or injury that initiated events								
L CE	PART II. Other algorificant condition	ns contributing to deeth b	out not resulting in	the underlying c	nuse given in	Part I. 24a. WAS	AN AUTOPSY	24b. WE	RE AUTOPSY FINDINGS
MEDICAL		ther algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							MPLETION OF CAUSE DEATH?
AN:	25. WAS CASE REFERRED TO MEDICAL			26. PLAC	E OF DEATN (C)	back only one)			e de la composición della composición della comp
2	EXAMINER?	HOSPITAL:		THEM:					
PHYSICIAN:	27. MANNER OF DEATN	1 ☐ Inpatient 2 ☐ ER/Outs 26e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	OF 28c. INJURY	AT	6 Other (Specify) 28d. DESCRIBE NOT	W INJURY OCCUR	ED	
ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 TYES	2 NO	201 1 2 2 7 2 1 2 2			
ETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED		ICIAN: To the best of my know ER: On the basia of examination						nuse(s) end	d manner as stated.
BE	29b. SIGNATURE AND TITLE DE CERTIFIE	//		21	c. LICENSE NU	MBER		GNED (Mo	nth, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WE				11/22	616	4	11	
	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Figo. Print) 491 / 166 / 105-5 L. +1 (2 Patules + Columbia May land, 31. DATE FILED (Monits, Day, Year) 32. REGISTRAR'S SIGNATURE								
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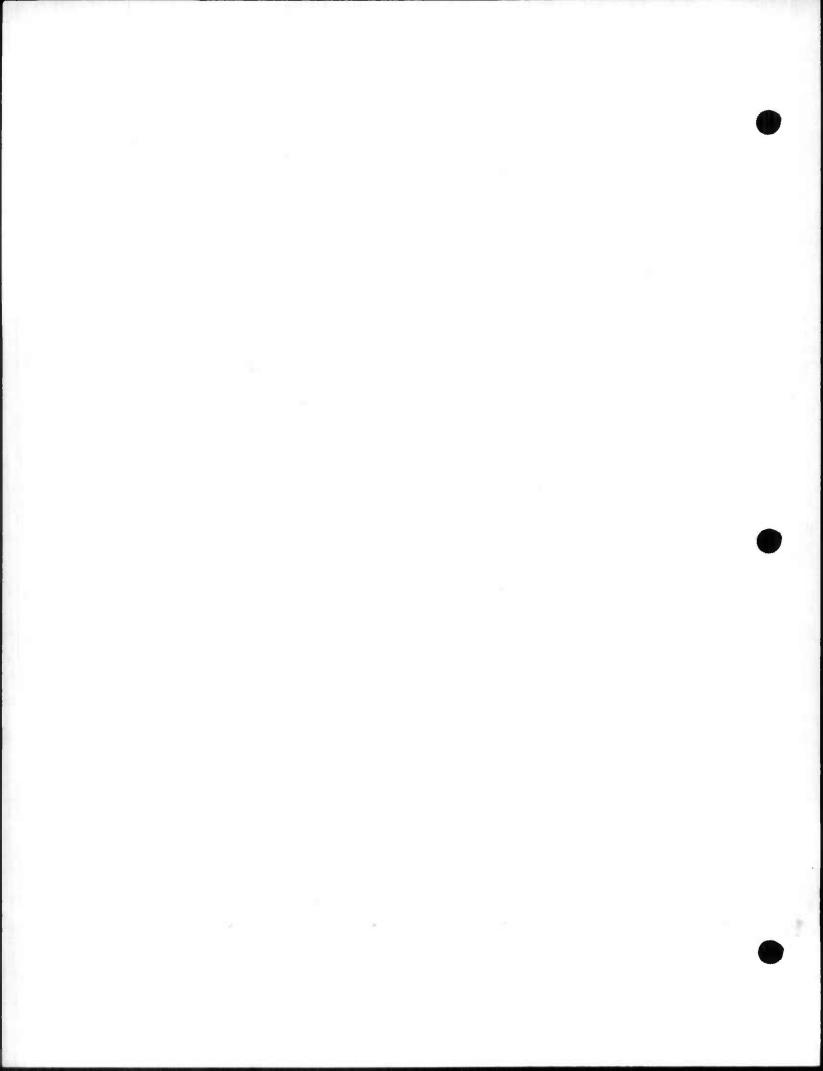
Md. 10e. STREET AND NUMBER 2423 Zion 11. MARITAL STATUS 1 Never Merried 2 M M 3 Widowed 4 Divorce	C. IREL S. 1 tution, give street Hospita DENT Ob. COUNTY Balt: Road	SEX M 2 F end number)		/3	YRS.		YEAR DAYS	IF UNDER	1	MARCH 9	, 1995	8. BIR	15:40
4. SOCIAL SECURITY NUMBER 212-14-3375 90. FACILITY NAME (# not instited to the second secon	tution, give street HOSPITA DENT OB. COUNTY Balt:	SEX M 2 F end number)		73	YRS.	MONTHS			24 HRS.	. DATE OF BIRT	Ή	8. BIR	TNPLACE (State or Fo
212-14-3375 9a. FACILITY NAME (If not institute of the control of	tution, give street Hospita DENT OB. COUNTY Balt: Road	M 2 G F end number)		73	YRS.	MONTHS						8. BIR	TNPLACE (State or Fo
St. Agnes RESIDENCE OF DECE 100. STATE Md. 100. STREET AND NUMBER 2423 Zion 11. MARITAL STATUS 11 Never Merited 2 M. 3 Widowed 4 Divorce	HOSPITA DENT OB. COUNTY Balt: Road	end number)				9h CITY							intry)
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Md. 10e. STREET AND NUMBER 2423 Zion 11. MARITAL STATUS 1 Never Merried 2 X M. 3 Widowed 4 Divorce	Balt: Road	imore										11/74	
10e. STREET AND NUMBER 2423 Zion H. MARITAL STATUS 1 Never Merried 2 M M. B Widowed 4 Divorce	Road	riiior.e		1.		TOWN OF		ION					10d. INSIDE CITY
th. MARITAL STATUS Never Merried 2 Miles University Miles University Miles M					La	nsdo	_	. ZIP CODE			1000		t VES 2X
th. MARITAL STATUS Never Merried 2 Miles Divorce							101		227		109. 0	US/	WHAT COUNTRY?
3 Widowed 4 Divorce		. WAS DECEDEN	T EVER IN	U.S. ARMEC	0	13. W	AS DECI			ORIGIN? (Speci	fy Yes or No-	14. BA	CE — American India
		FORCES? 1 IF YES, GIVE W				lf.	yes, spe	2 X NO	n, Mexicen, Specify:	Puerto Rican, et	c.)	Bla	ecify:
	ENT'S EDUCATI												white
(Specify only h	ighest grade con	npleted)		18e. DECED (Give k	DENT'S US and of wo NOT use	ork donn du	ring mos	IN st of workin	g	16b. KIND C	F BUSINESS/	NDUSTRY	
Elementary/Secondary (0-12	r) C	N/A	٠)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Fa	ctory		
17. FATHER'S NAME (First, Midd	fie, Last)	10/10		Edbo	101			ts. MOTH	IER'S NAME)	
John Ire	land							Ka	theri	ne Sus	an	,	
				196. M	AILING A	DDRESS	Street ar	nd Number	or Rural Roo	te Number, City o	or Town, State,	Zip Code)	
				24:	23 Z	Zion	Roa	d, L	ansdo	wne, Mo	d. 21	227	
109. METHOD OF DISPOSITION	N 3 □ Removal	from State	20b.	PLACE AND	DATE OF	DISPOSIT	ION (Na	me of		OATE 20			
		and I	C(edar	HITT	_	_	_			Glen	Burn:	ie, Md.
97	7	PF	1								al Hom	e of	Flk In
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ahock, or hea	rt failure. List	only one cau	t ceused ise on ea	the deeth. sch line.	. Do no	t enter t	he mod	de of dyli	ng, auch	s cardiac or	reaptratory	rreat,	Approxima
		Runin	Chan		D.:	1- 0			_				Onset and
reaulting in death)	A						ere	Della	ar In	tarct			24 hr
f any, leeding to immedia	ite	DUE TO	(OR AS A	CONSEQUEN	NCE OF):								
CAUSE (Disease or Injury													
		DUE 10	(OH AS A	CONSEQUE	NCE OF):								
	d												
PART II. Other significent	conditions co	ontributing to	death bu	ut not resu	Iting in	the und	erlyIng	cause g	lven in Pa			Y 24	Ib. WERE AUTOPSY FIN
										- X□ Y	ES 2 NO		COMPLETION OF CO OF DEATH?
DID TORACCO HER	CONTRIB	LITE TO CA	LICE OF	- DEATH			_ 745			_			1 XYES 2 N
		UIE IO CA						UNC	ERTAIN				
EXAMINER?	H				C	OTHER:							
		28a. DATE OF	INJURY		b. TIME (OF 2	8c. INJU	JRY AT				CCUREO	
		(Month, Di	ay, Year)	İ	INJUR	M							
3 Suicide 6 Co		28e. PLACE Of building.	F INJURY -	— At home,	ferm, stre	eet, fector	y, office		2	BI. LOCATION (S	treet and Numb	er or Rural	Route Number,
4 Homicide date	ermined									Ony or lown,	Siele/		
(Check only	ING PHYSICIAN	: To the beat of	my knowle	edge, death o	occurred	at the tim	e, date d	end place,	end due to	the cause(e) end	d manner ea s	tated.	
													(e) end menner ee ats
96. SIGNATURE AND TITLE OF	CERTIFIER							29c. LICEI	NSE NUMBE	R	29d, D/	ATE SIGNE	D (Month, Day, Year)
Best 3,7	norte	E, M	D.					D08	949		•	Marc	h 10, 19
							000			_			
LETE L. MOLEO		3 pegis na		es Ho	spit	tal,	900	Cat	on Av	re., Ba	ltimor	e, M	ld. 21229
	JOHN ITE JOHN ITE JOHN ITE JOHN ITE 199. INFORMANT'S NAME (PIPE) Margaret A. 209. METHOD OF DISPOSITION 10 Burlet 2 Cremetich 6 Donation 5 Other (S) 21. SIGNATURE OF PURE AL 23. PART I. Enter the dise ahock, or hea IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list condition resulting in death) Sequentielly list condition Further and condition Further and condition Further and condition Sequentielly list condition Further and condition Further and condition DID TOBACCO USE S. WAS CASE REFERRED TO R EXAMINER? 1	John Ireland Jo	John Ireland 190. INFORMANT'S NAME (Type/Print) Margaret A. Ireland 190. INFORMANT'S NAME (Type/Print) Margaret A. Ireland 200. METHOD OF DISPOSITION 10. Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNE AL SERVICE LICENSE 22. PART I. Enter the diseases, or complications the shock, or heart falture. List only one cause. IMMEDIATE CAUSE (Finel disease or condition reaulting in death) 3. Brain DUE TO Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CA 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 Repair (Month, D. 1) 27. MANNER OF DEATH 1 Statural 5 Pending Investigation 3 Suicide 6 Could not be determined 28. PLACE O building, On the basis of experiment of the basis of the basis of experiment of the basis of the basis of the basis	John Ireland 199. INFORMANT'S NAME (Type/Print) Margaret A. Ireland 209. METHOD OF DISPOSITION 10. Buriel 2 Cremation 3 Removal from State 11. Signature of Funes AL Service Licenses 21. Signature of Funes AL Service Licenses 22. PART I. Enter the disease a or complications that ceused abook, or heart failure. List only one cause on each ook, or heart failure. List only one cause on each ook, or heart failure. List only one cause on each ook, or heart failure. 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Enter the diseases, or complications that ceused the death abock, or heart failure. List only one cause on each line. 126. PART II. Enter the diseases, or complications that ceused the death abock, or heart failure. List only one cause on each line. 126. PART II. OR AS A CONSEQUE 127. MAINTER CONSEQUE 128. WAS CASE REFERRED TO MEDICAL EXAMINER? 128. WAS CASE REFERRED TO MEDICAL EXAMINER OF DEATH 1 Services 2 M NO 1 Inpatient 2 (XER/Outpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatie	John Ireland 196. INFORMANT'S NAME (*I/po/Print) Margaret A. Ireland 2423 2 206. PLACE OF DEATH 2423 7 207. PLACE OF DEATH 2423 7 208. METHOD OF DISPOSITION 1/1 Burlet 2 Certifier 208. PLACE OF DEATH 209. METHOD OF DISPOSITION 1/2 Burlet 2 Certifier 209. METHOD OF DISPOSITION 1/2 Burlet 2 Certifier 200. PLACE AND DATE OF Cappelory, cremetory or print of the print o	John Ireland The Inference of the properties of	John Ireland 196. BRORDMANT'S NAME (Type/Print) Margaret A. Ireland 196. BRORDMANT'S NAME (Type/Print) Margaret A. Ireland 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2423 Zion Roa 2426 Zion Roa 2426 Zion Roa 2426 Zion Roa 2427 Zion Roa 2427 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 250 PLACE AND DATE OF DISPOSITION (No. 260 Zion Till Cemete 221 NAME AN 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 2428 Zion Roa 250 PLACE OF DEATH Demotrate the more above, or the print of the more above, or heart fallers. List only one cause on each line. 250 PLACE OF RAS A CONSEQUENCE OF): 250 DUE TO (OR AS A CONSEQUENCE OF): 251 DUE TO (OR AS A CONSEQUENCE OF): 252 DUE TO (OR AS A CONSEQUENCE OF): 253 DUE TO (OR AS A CONSEQUENCE OF): 254 DUE TO (OR AS A CONSEQUENCE OF): 255 DUE TO (OR AS A CONSEQUENCE OF): 265 DUE TO (OR AS A CONSEQUENCE OF): 266 DUE TO (OR AS A CONSEQUENCE OF): 276 DUE TO (OR AS A CONSEQUENCE OF): 277 DUE TO (OR AS A CONSEQUENCE OF): 278 DUE TO (OR AS A CONSEQUENCE OF): 279 DUE TO (OR AS A CONSEQUENCE OF): 287 PLACE OF DEATH YES IN O 288 DEATH OF DEATH YES IN O 289 DEATH OF DEATH YES IN O 290 DEATH OF	TRAINER'S NAME (First, Middle, Last) John Ireland 196. INFORMANT'S NAME (TyperPrint) Margaret A. Ireland 2423 Zion Road, L 252 NAME AND ADDRESS (Street and Number Completery) 253 PART I : Enter the disease(a, jor complications that caused the death. Do not enter the mode of dyling and control of the cause on each line. 254 NAME AND ADDRESS (Finel death) 255 Name And Address of conditions, and control of the cause on each line. 255 Name And Right Cerebell: 256 Name And Right Cerebell: 257 DUE TO (OR AS A CONSEQUENCE OF): 258 Sequentially list conditions, and resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 259 DUE TO (OR AS A CONSEQUENCE OF): 260 DUE TO (OR AS A CONSEQUENCE OF): 270 DUE TO (OR AS A CONSEQUENCE OF): 271 DUE TO (OR AS A CONSEQUENCE OF): 272 DUE TO (OR AS A CONSEQUENCE OF): 273 DUE TO (OR AS A CONSEQUENCE OF): 274 DUE TO (OR AS A CONSEQUENCE OF): 275 DUE TO (OR AS A CONSEQUENCE OF): 276 DUE TO (OR AS A CONSEQUENCE OF): 277 DUE TO (OR AS A CONSEQUENCE OF): 278 PLACE OF DEATH YES NO UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNCOUNTY UNcounty Unco	15. MOTHER'S NAME (First, Middie, Last) 16. MOTHER'S NAME (Katheri John Ireland 16. MOTHER'S NAME (First, Middie, Last) 16. MAILING ADDRESS (Street and Number or Rural Flow 24.23 Zion Road, Lansdo 24.23 Zion Road, Lansdo 24.23 Zion Road, Lansdo 24.23 Zion Road, Lansdo 24.25 Zion Road, Lansdo 25.25 Zion Zion Zion Road, Lansdo 25.25 Zion Zion Zion Zion Zion Zion Zion Zion	15. MOTHER'S NAME (First, Middle, Last) JOHN Ireland 16. INFORMANTS NAME (First, Middle, Last) JOHN Ireland 17. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Test only one) 18. MOTHER'S NAME (First, Middle, Last) Last only one superior and Number or Part In Impedient 2 423 Zion Road, Lansdowne, Middle,	The Part II. Other significant conditions, as a consequence of): Sequentially late conditions resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially late of DEATH DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):	18. MOTHER'S NAME (Front, Mickin, Lasi) 18. MOTHER'S NAME (Front, Mickin,



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within "24 hours after death. Page 6 may be retained by the hoss	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tunneral director, page 5 should be detached		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical ansuminer must be notified at once.	ı
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	The The	cate	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal	Hem	
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1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH CERTIFICATE OF DEAT	
1. DECEDENT'S NAME (First, Middle, Last) CARL VENSON	JOHNSON SR.	2. DATE OF DEATH DAY MARCH 0.7

	1. DECEDENT'S NAME (First, Middle, L CARL VENS		JOHNSON	J SR.			2, 0	DATE OF DEATH	DAY	YEAR 3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	0.(1	IF UNDER 1 YEA	II IF UNDER 24 HF		ARCH O	9.95 11:56 PM 8. BIRTHPLACE (State or Foreign			
	225-56-6981	XX M 2 _ F			MONTHS DAY		N. (4	Month, Day, Year) 1-18-42		Country)		
	9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH								9c. COU	VIRGINIA NTY OF DEATH		
D HOT	JOHNS HOPKINS HOSPITAL BALTIMORE CITY											
REC	10a, STATE 10b. COUNTY									10d, INSIDE CITY LIMITS?		
LDI	MARYLAND 100, STREET AND NUMBER			BA	LIIMOH	RE CITY				1√1 YES 2 □ NO		
RA	101. 21 COL											
O.	2126 Park Ave	12. WAS DECEDEN	IT EVER IN U.S. AR	MED		ECENDENT OF HIS	SPANIC OF			14. RACE — American Indian,		
BY FUNERAL DIRECTOR	1 Never Married 2 Married FORCES? 1 YES 2 No. 3 Widowed 4 Divorced FORCES?				∆ NO If yes, specify Cuban, Mexican, 1 ☐ YES 2 V NO Specify:				Specify:			
	16. DECEDENT'S (Specify only highest (EDUCATION Production	16a. DE	CEDENT'S U	SUAL OCCUP	ATION		16b. KIND OF BU	ISINESS/INC	BLACK		
LET	Elementary/Secondary (0-12)	College (1-4 or 5	Hite.	Do NOT use	retired.)	most of working		MACTI	- 1401	CCNCNT		
COMPLETED	11th grade 17. FATHER'S NAME (First, Middle, Last)		TRUCK	DRIVE		NAME (E	WASTI		AGEMENT		
BE C	DAVID JOHNSON							JOHNSON	Surnamej			
0	190. INFORMANT'S NAME (Type/Print) Helene Johnson		191	MAILING A	DORESS (Stre	et end Number or Ru	ural Route	Number, City or Tox	vn, State, Zip	Code)		
	20a, METHOD OF DISPOSITION WABURIAL 2 Cremation 3 1				DISPOSITION	venue, B				City or Town, State		
	1X Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cre	matory or other	ar placa)		1			wn, Virginia		
	21, SIGNATURE OF FUNERAL SERVICE	ELICENSEE (11011 111		22. NAME	AND ADDRESS OF	FFACILITY	1				
	• ///	Drou			1206	iam C.	th A	ANIIA				
	IMMEDIATE CAUSE (Final disease or condition	ire. List only one cau	ise on each line							interval Returns		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ### Leuse Atlantic Carling of Carling and Death Onset and Death Onset and Death											
NO.	Sequentially list conditions,	Sequentially list conditions, if any, leading to immediate our TO (OR AS A CONSEQUENCE OF):										
MEDICAL CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	c										
TIF	that initieted events resulting in death) LAST	DUE TO	(OR AS A CONSEC	DUENCE OF):								
CE		d										
CAL	PART II. Other algnificant condi	tions contributing to	deeth but not re	esuiting in	the underly	ing ceuse given	in Part	i. 24a. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
EDI								1 TES		COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CO	NTRIBUTE TO CA	USE OF DEA	TH YES	□ NO	☐ UNCERT	AIN [insp	ection	1 TES 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	26. PLAC		(Check only or	ne)						
PHYSICIAN:	1 XES 2 NO 27. MANNER OF CEATH	1 Inpatient 2 I			☐ Nursing H	ome 5 Aesiden		Other (Specify) DESCRIBE HOW				
ВУ Р	Natural 5 Pending	(Month, D	ay, Year)	INJUI	PY 1	WORK?	200.	DESCRIBE HOW	INJUNY OCC	JUNEO		
COMPLETED E	3 Suicide 6 Could not determine	pullaing.	F INJURY At hor etc. (Specify)	me, ferm, atr	eet, fectory, of	fice		LOCATION (Street City or Town, State		or Rural Route Number,		
1	29a. CERTIFIER (Check only	IYSICIAN: To the best of	my knowledge, des	nth occurred	at the time, d	ite end place, and	due to the	cause(e) end me	nner ee state	nd.		
SO			xamination end/or i	nveatigation,	In my opinion	, death occured at	the time,	date end place, er	nd due to th	e cause(e) end manner ee stated.		
#	296. SIGNATURE AND TITLE OF CERT		-/-			29c. LICENSE				SIGNEO (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	DEATH (ITEN	1 27) (Type, P	rint)		.M.E			RCH 08,1995		
	THEODURE 1	1.K.A		11 N	. PEN	N ST. H	BALI	'IMORE,	MARY	LAND 21201		
	MAR 1 4 1995	whi distant	R'S SIGNATURE									



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Reath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	10	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fut be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	불
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	1 - FOR STATE OF MARY	LAND / DEPAR	TMENT OF HEALT	H AND ME	NTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)	OLITIII	OAIL OF DE		DATE OF DEATH		3. TIME OF DEATH			
	Anne Gotta - Jagues				MONTH DA	1995				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR IF UN	DER 24 HRS. 7.	DATE OF BIRTH	8. BIR	THPLACE (State or Foreign			
	43-14-8331 43-14-8331 1 D M 2 D F	74 YRS.	MONTHS DAYS HOUR	S MIN.	(Month, Day, Year) Feb. 24.	Cou	ntry)			
	9a. FACILITY NAME (If not institution, give street and number)	9c. COUNTY OF	CT DEATH							
le E	St. Agnes Hospital Baltimore									
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	SIDENCE OF DECEDENT								
DIRECTOR	CT Fairfield	Fairfield Bridgeport 10d. INSIDE CITY								
	10s. STREET AND NUMBER	1 YES 2								
NA.	106. STREET AND NUMBER 106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF W USA									
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DECENDEN	T OF HISPANIC O	RIGIN? (Specify Yea	or No. 14 BAI	CE — American Indian,			
	1 Never Married 2 Married FORCES? 1 YES	2 X NO	If yes, specify Cu 1 ☐ YES 2 😡 N	iben, Mexican, Pi	uerto Rican, etc.)	Bla	ck, White, etc.			
BY	3 Widowed 4 Divorced		N	о зрвску.		Spe	white			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of w	USUAL OCCUPATION ork done during most of wo	rkina	16b. KIND OF BUS	INESS/INDUSTRY				
"	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT us	e retired.)							
M	12 7+	Profess	or of Nursi				y College			
	17. FATHER'S NAME (First, Middle, Last)		18. M		First, Middle, Malden S					
BE	Paul Gotta 190. INFORMANT'S NAME (Type/Print)				le Kushel					
2	William Jaques		ADDRESS (Street and Num				5.0			
	20e. METHOD OF DISPOSITION		Cahill Way,	Lake M						
	TCABurlat 2 Cremation 3 Removal from State complete, crematory or other place!									
	4 Donation 5 Other (Specify) Lakeview Cemetery 3/16 Bridgeport, CT 21. SIGNATURE-OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
	A Make A		Sterling	Ashton	Funeral	Home				
\vdash		10801	736 Edmon	dson Av	renue, Ba	1to, Md	. 21228			
	23. PART I. Enter the diseases, or complications that cause shock, or heert fallura. List only one cause on	each line.	ot entar the mode of o	dying, such aa	cardiac or respir	atory arrest,	Approximate Interval Batween			
	IMMEDIATE CAUSE (Final disease or condition	1 0					Onset and Death			
	resulting in daeth) e. Dra	C Q V	ne-				10days			
-		A GONDEOUENUE OF	,							
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate	A CONSEQUENCE OF):				-			
3	ceuse. Enter UNDERLYING CAUSE (Disease or Injury									
I E	that initiated events resulting in desth) LAST	A CONSEQUENCE OF	:							
出	d									
AL C	PART II. Other aignificant conditions contributing to death	out not resulting is	the underlying cause	e given in Part	I. 24s. WAS AN A	UTOPSY 24	b. WERE AUTOPSY FINDINGS			
1 ()	hung Cancer				PERFORI	. 4	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC					1 - YES 2	A.00	OF DEATH?			
	DID TOBACCO USE CONTRIBUTE TO CAUSE O	OF DEATH YES	S NO UN	ICERTAIN [<u> </u>		1 123 2 2 100			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEAT	(Check only one)							
SI	1 VES 2 NO HOSPITAL: 1 Input lent 2 ER/Out	patient 3 DOA	OTHER: 4 Nursing Home 5	Residence 6 🗆	Other (Specify)					
PH	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	28b, TIME		26d	I. DEȘCRIBE HOW IN	JURY OCCURED				
BY	1 Netural 5 Pending 2 Accident investigation		M 1 TYES 2	□ NO						
	3 Suicide 6 Could not be 28e. PLACE OF INJUR building, atc. (Spe determined	f — At home, farm, st cify)	reet, factory, office	281.	LOCATION (Street on City or Town, State)	nd Number or Rural	Route Number,			
鱼	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my know one)									
COMPLETED	2 MEDICAL EXAMINER: On the basis of examination	n and/or investigation	, in my opinion, death occ	oured at the time,	dete end place, end	dus to the cause(e) and manner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	0 4 1	29c. LJ	CENSE NUMBER			D (Month, Day, Year)			
0	Jas. The H	nih)		402	279	Mar	12,95			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OR	ATH (ITEM 27) (Type,	Spitel E	-,0						
	31. DATE FILED (Month, Dey, Year) 22. REGISTRAR'S SIGN		1019 6	- 1/ ,						
	MAR 1 4 1995 Jahr Day Year)	4								
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within SK hours after death. Page 6 may be retained by the hospital or attending physician.

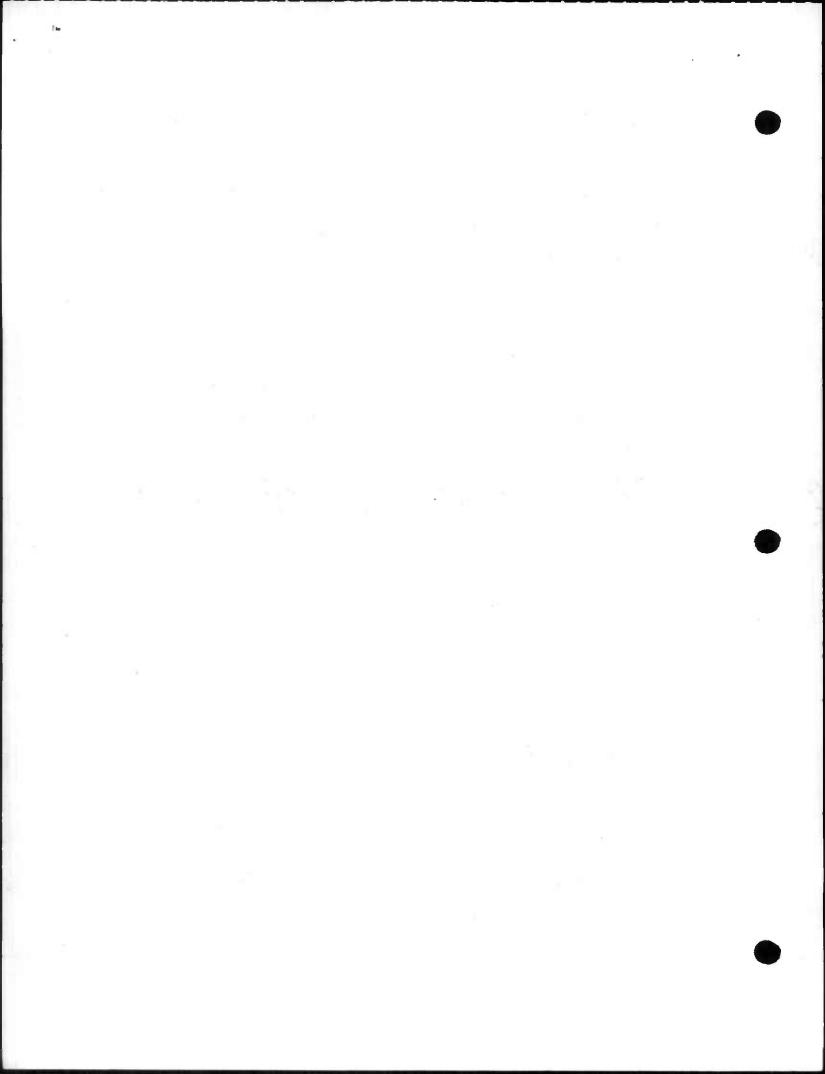
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	7.0	ECED	ENT'S	S NA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		ÇER	TIFIC	AIE UF	DEATH	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) TAMES D. JA	CKSON					2. DATE OF MONTH	DEATH DA	y 4	YEAR 7	3. TIME OF DEATH
		5. SEX 6. A	GE (In yrs. last bir		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, De	ny Waari	1075	Country	
	9a. FACILITY NAME (If not institution, give street		73		o, CITY, TOWN	OR LOCATION OF D	SEPTEME	SER 19		NTY OF O	ARYLAND
HZ	MERCY MEDICAL CENTER			"	BALTIMORE CITY						,
5	RESIDENCE OF DECEDENT						CITI				
DIRECTOR	MD 106. STATE 106. COUNTY				D., C_						10d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	1307 DECATUR STREET				10	f. ZIP CODE	230		10g. CITI		HAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMEI FORCES? 1 YES 2) NO IF YES, GIVE WAR OR DATES				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuben, Maxicen, Puerto Ricen, etc.) 1 ☐ YES X NO Specify:					14. RACE Bleck Specif	— American Indian, , Whita, alc.
ED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	FION mointage	16a. DECED	ENT'S USL	UAL OCCUPATI	ON	16b. KII	OF BUS	INESS/IND		
COMPLETED		College (1-4 or 5+)			done during metired.)	ost of working			•		
MP	7тн -			ONGSH	OREMAN			,	SHIPPI	ING	
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA			Sumame)		
H	ROLAND JACKSON 19a. INFORMANT'S NAME (Type/Print)	<u></u>	405.14		22500 10	LARR and Number or Rural	IE M. Sc				
5	CATHERINE M. JACKSON					TREET, BAL				21230	
	20a. METHOD OF DISPOSITION 1	al from Stats	20b. PLACE AND	DATE OF D	ISPOSITION (N	ame of	DATE	20c. LOC	ATION —	City or To	
	4 Donallon 5 Other (Specify)	loss A	GREEN INC	DUNT C		Y, MARCH 8		<u> </u>	ALTIMO	DRE CI	ITY
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVENUE, BALTIMORE, MARYLAND 21230							21230			
	23. PART I. Enter the diseases, or con	nplications that cau	sod_the death.	. Do not	1 1/01 -	• I OIVI / VAL	YUL/ DAL		_/	V I L-CHAL	Approximate
-	shock, or heart fallure. Lis IMMEDIATE CAUSE (Final										Interval Between Onset and Death
	disease or condition resulting in death)	GAS	Tric	C	ANC	Eni					12 mos
			AS A CONSEQUE								
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUEN	NCE OF):							
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury										ļ
E	that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQUE	NCE OF):							
H	d.										
	PART ii. Other algnificant conditions	contributing to deat	h but not reau	fting in ti	ha underlyin	g cause given in	Part i. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL								PERFORI	2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC									1		DF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTRIB	BUTE TO CAUSE	OF DEATH	YES	□ NO □	UNCERTAI	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IQSPITAL:	28. PLACE OF		Check only one)						
IXSI	1 YES 2 NO	Inpetient 2 - ER/C		DOA 4 [Nursing Hon	ne 5 🗆 Residence	6 Other (Sc	ec/fy)			
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Yes		b. TIME OF	W	IURY AT ORK?	28d. DEŞCRI	BE HOW IN	JURY OCC	CURED	
2 Accident Investigation 3 Suicide 8 Could not be detarmined 4 Homicide Homicide Homicide City or Town, State) 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Ni City or Town, State)							od Number	or Burni B	nute Number		
							oute number,				
COMPLET		N: To the beat of my kr									and manner as stated.
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NU	MBER		29d. DATE	SIGNEO	(Month, Day, Year)
BE	nipolale	m				D24 10	16		▶ 3	3/6/	95
5	30. NAME AND ADDRESS OF PERSON WHO C	OWA LE	DEATH (ITEM 27)	(Type, Prin	301	5+ F	2.1 1	P1.	R.	1+2	Md 21222
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	IGNATURE		201	-1 /	10/	/ . /		110)	1.10012
- N	MAK EEELT AAM	d in inmitted to	PULL								



DIVISION OF VITAL RECORDS, P.O. BOX 687604

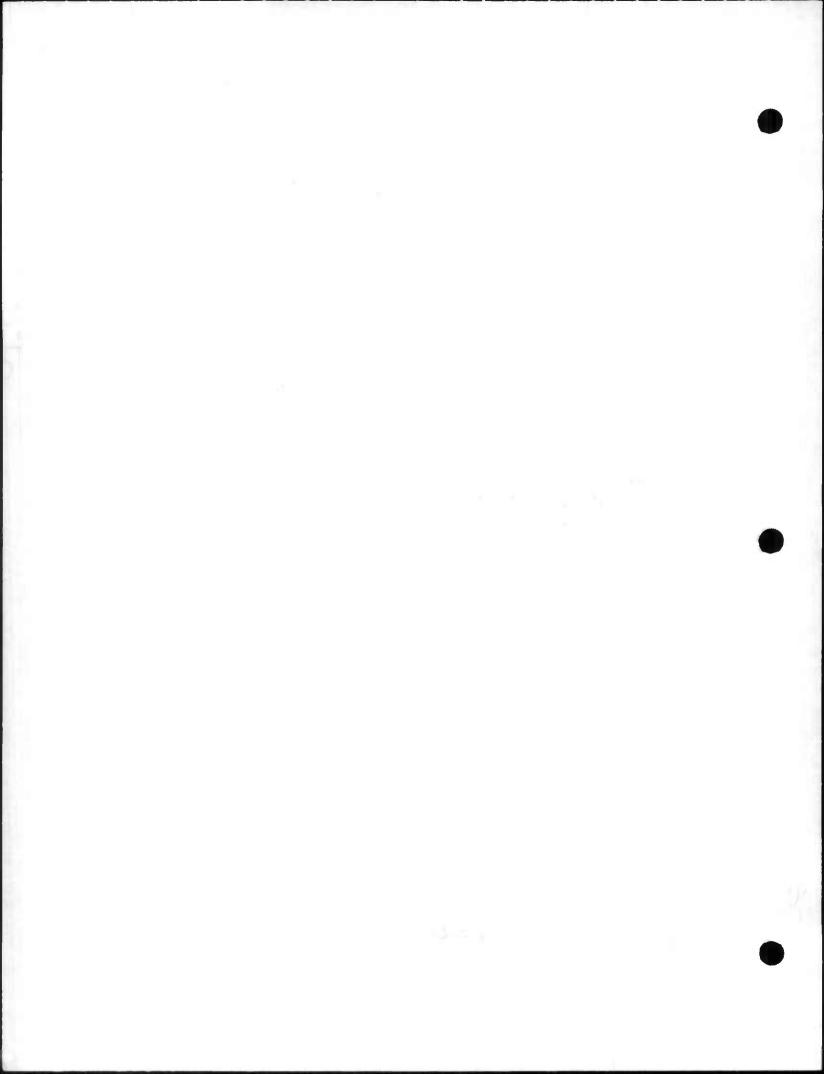
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	C	ERTIFIC	ATE OF	DEATH	REG. NO	D		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
		STINE KI	LLAM,	JR.		MARCH 12	, 1995	EAR // 20 M	
	A STATE OF THE STA	SEX 8. AGE (in yrs. les 61		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 09-18-19	B.	BIRTHPLACE (State or Foreign Country) ARYLAND	
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH							Y OF DEATH	
DIRECTOR	295 MACKINTOSH I	DRIVE	G1	LEN BU	JRNIE		ANNE	ARUNDEL	
106. STATE 106. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE C									
								LIMITS? 1 VES 2X NO N OF WHAT COUNTRY?	
FUNERAL	295 MACKINTOSH I			2	21061	.U.S.A.			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES XIXA IF YES, GIVE WAR OR DATES	MED NO	If yes, spe	ENDENT OF HISPA letty Cuban, Maxico 2 X NO Specif	ne or No 14	or No— 14. RACE — American Indian, Black, White, etc. Specify: WHITE		
9	15. DECEDENT'S EDUCATI (Specify only highest grade con		CEDENT'S USU	AL OCCUPATIO	N	18b. KIND OF BI	SINESS/INDUS	TRY	
COMPLET		College (1-4 or 5+) #fe.	Do NOT use ret	done during mos tired.) E AGEI		INSURA		ND BONDING	
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maide	Surname)		
BE (CLINTON ALISTIN	E KILLAM, SR	•		MARGARE	ET ELLEN	BROO	KS	
0	19a. INFORMANT'S NAME (Type/Print) LYNNE EDTTH					Route Number, City or To			
	BDIII				_	VE, GLEN		IE, MD. 2106	
	29a. METHOD OF DISPOSITION 11 Burlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	GRANI	TE PR	ESBYTE	ERIAN	3/14/ GR	ANITE	, MD.	
	21. SIGNATURE OF ELINERAL SERVICE LICENS	2/1/2-		L SECO	OND AVE	OUTYSINGLE NUE, S.W MARYLAN		UNERAL HOME,	
	23. PART I. Enter the disease, or com	iplications that caused the de	eth. Do not e	enter the mod	te of dving, suc	h as cardiac or resu	dratory arrest	t, Approximate	
	shock, or heart feilure. List IMMEDIATE CAUSE (Final	t only one cause on each line						Interval Between Onset and Death	
	disease or condition resulting in death)	Renal faulu DUE TO (OR AS A CONSEC	u						
		A						5 years	
NO	Sequentially list conditions, b	DUE TO OR AS A CONSEC						6 years	
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		,					į į	
CERTIFICATION	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEC	DUENCE OF):						
H	d								
4	PART II. Other significant conditions of	ontributing to deeth but not re	esuiting in th	e underlying	ceuse given in	Part I. 24s. WAS AI		24b. WERE AUTOPSY FINDINGS	
DICAL	Congestive he	eart failin	4			PERFO		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
E I								1 TYES 2 THO	
PHYSICIAN:	DID TOBACCO USE CONTRIB				UNCERTAIL	NO			
S		OSPITAL:		HER:					
¥	27. MANNER OF DEATH	☐ Inpatient 2 ☐ ER/Outpatient 3 28e. DATE OF INJURY	28b. TIME OF			6 Other (Specify)	IN RIGHT COOKIN		
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WOR	ES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCUR	ED	
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY At hor building, stc. (Specify)	me, farm, street			281. LOCATION (Street	and Number or I	Rural Route Number,	
	4 Homicide determined	Suitaring, and Opechy)				City or Town, State)		
COMPLETED		N: To the best of my knowledge, dea On the basis of examination and/or in						ause(a) and manner as stated	
ШС	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI				
∞	Ster Jen	M.D.			DZIZZ			ISNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERIODS WHO CO	OMPLETED CAUSE OF DEATH (ITEM	1 27) (Type, Print	1)					
	Stephen Zemel	M.D 795 x	79094	ost R	1 4203	Glen Bo	raip	MD ZIOCI	
	MAR 1 4 1995 July	32 AREGISTRAR'S CONSUM					1		



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detached	Health and Mental Hyglene prior to burial, cremation, or removal.	0000
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funeral d		ows any injury, or other traumatic event, the medical axaminar must be notified at once
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Michael

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

Sylva,

OR ATTENDING PHYSICIAN: The law

HOSPITAL

95 07633 IYEM: 1. PER F.H. FILM G-721 3/14/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH JOSEPH CLEMENT KNAPP. SR Joseph C. Knapp March 12 1995 08:32 A. M 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH
09-02-1927 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 218-22-9220 67 X M 2 | F DAYS HOURS YRS MARYLAND 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NORTH ARUNDEL HOSPITAL A.A.COUNTY GLEN BURNIE 10a. STATE 105 COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND GLEN BURNIE ANNE ARUNDEL 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21060 U.S.A. 1031 GENINE DRIVE 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? ∑ ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuben, Mexican, Puerto Rican, etc.)
 The Yes 2s No Specify: 14. RACE - American Indian, Black, White, etc. 1 Never Merried 2 K Merried Specify: WHITE BY 3 Widowed 4 Divorced ETED 15. OECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi Elementary/Secondery (0-12) NONE COMPL CARPENTER CONSTRUCTION COMPANY 11 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maide SIMONDS **JAMES** KNAPP, SR. PEARL MARIE ROBERT BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 EDNA MAY KNAPP 21060 1031 GENINE DRIVE, GLEN BURNIE, 20s. METHOD OF DISPOSITION
1 Burtel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemeter, crematory or other place)
GLEN HAVEN MEMORIAL PR 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) GLEN BURNIE, MD. 22. NAME AND ADDRESS OF FACILITYS INGLETON FUNERAL HOME, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 23. PART I. Enter the diseases, or complications that counted the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heert feliure. List only one ceuce of each line. Approximate IMMEDIATE CAUSE (Finel Onset and Death disease or condition ccordea resulting in death) DUE TO OR AS A CONSEQUENCE OF bertrala CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate (troin cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSECULA that initieted events resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuee given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE t 🗌 YES 2 🗌 NO DE DEATH? 1 TYES 2 ZONO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: t YES 2 NO 1 Inpatient 2 B ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, t P Natural 5 Pending M t YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 65 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined 4 Homicide 28 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. TO THE HOSPITAL OF THE FUNERAL OF THE MITTER TO THE MITTER 2 ___ MEDICAL_EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner ea stated. 28b. SIGNATURENAND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

1600 Crain HighwayS.#302, Glen Burnie, Maryland 21061

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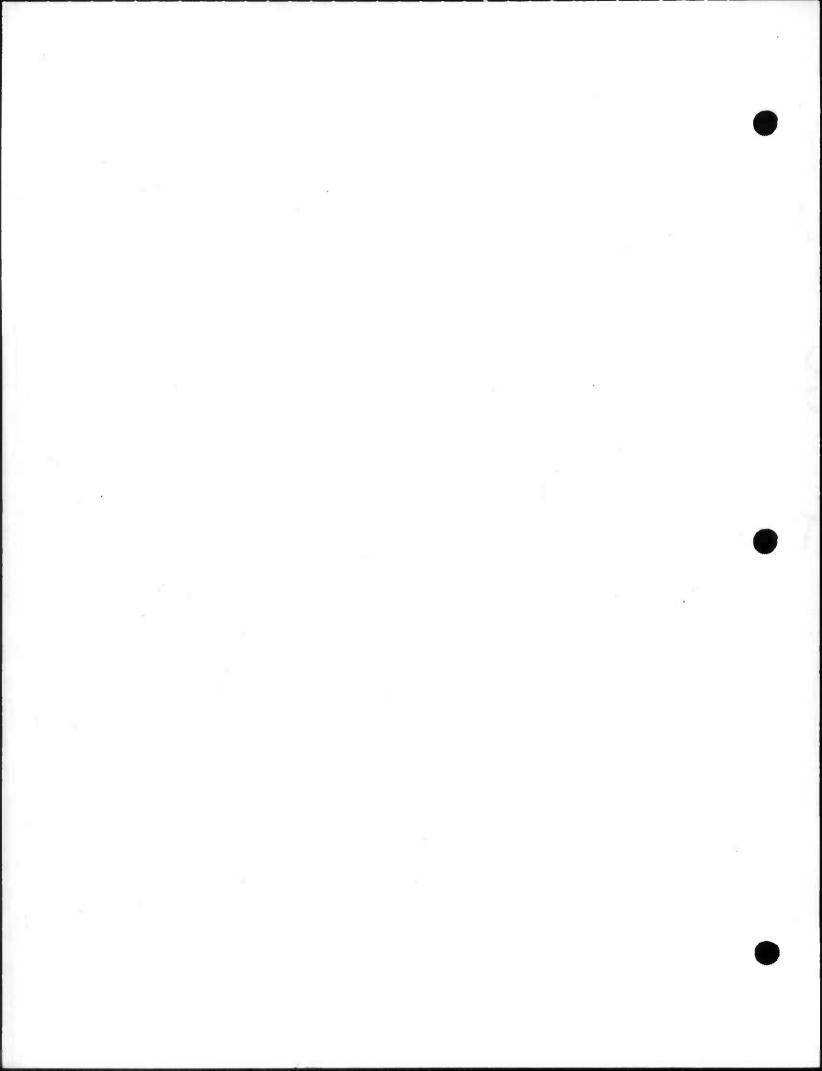
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DIVISION OF VITAL RECORDS, P.O. BOX 6876

STATE OF MARYLANI) / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	BEG NO

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMEN CERTIFICAT			NTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3. TIME OF DEATH
	FRANK	C. KI	RSCHNE	=R			9 199	95 10:081
	4. SOCIAL SECURITY NUMBER		rs. lest birthday) IF UND	ER 1 YEAR IF UNDE	R 24 HRS. 7.	DATE OF BIRTH	6.	BIRTHPLACE (State or Foreign
	212-05-0755 9e. FACILITY NAME (If not institution, give stree	1 X M 2 □ F 94	YRS. MONTHS	DAYS HOURS		(Morth, Day, Year) Aug. 18,	1900	Maryland
S S	Saint Mary's Hos			onardto			St.	Mary's
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY							-
DIRECTOR		timore	10c. CITY, TOWN	nda1k				10d. INSIDE CITY LIMITS? 1 YES 2 Y NO
	10e. STREET AND NUMBER	DIMOTE		101. ZIP COL	DE		10a. CITIZEN	OF WHAT COUNTRY?
FUNERAL	3446 Liberty Par	rkwav		2122	2		U.S.	
S		2. WAS DECEDENT EVER IN U.S	S. ARMED 13	. WAS DECENDENT	OF HISPANIC O	PRIGIN? (Specify Yes		
	1 Never Married 2 Married	FORCES? TYPES 2	NO S	If yes, specify Cub	en, Maxican, Pu	uerto Rican, etc.)		. RACE — American Indian, Black, White, etc. Specify:
ВУ	3 🔀 Widowed 4 □ Divorced	IIWW & IWW	U.S.A.	XX	орошу.		1	WHite
ETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION 16/	a. DECEDENT'S USUAL (Give kind of work don	OCCUPATION	ina	16b. KIND OF BUS		
Ę.		College (1-4 or 5+)	life. Do NOT use retired.)				
COMPL	12 yrs		Manager			Phone	Compa	any
	17. FATHER'S NAME (First, Middle, Lest) Charles A. Kirs	h				First, Middle, Malden		
8	19a. INFORMANT'S NAME (Type/Print)	cnner				len Py		
2	Jacqueline Phil	Inot	19b. MAILING ADDRE					
	20a. METHOD OF DISPOSITION	*	3446 Li		KWY.,			
	1 X Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State cemeter	y, crematory or other place	e)			-	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICEN	IPar	kwood Ce	Metery . NAME AND ADDRE	3-1	3-95 I	Baltir	more, Md.
	- Edwar U E	4		Bradley	-Asht	on Fune	eral E	21222 Home, Inc. alto.,Md.
	23. PART I. Enter the diseases, or con shock, or heert failure. Lis	nplicetions that caused the	e deeth. Do not ente	er the mode of dy	ring, auch es	cerdiec or respi	ratory arreat	, Approximate
	IMMEDIATE CAUSE (Final							Onset and Dea
	disease or condition resulting in death)	be	lateral properties of the second properties of	neum	ania			hours
		DUE TO (OR AS A CO	NSEQUENCE OF):					
8	Sequentially list conditions, b.							
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEOUENCE OF):					
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	NSECUENCE OF:					
Ē	resulting in death) LAST	700 10 (011 110 11 00)	notocator or j.					
핑	d							
¥	PART II. Other aignificent conditions of	contributing to deeth but r	not resulting in the u	inderlying ceuse	given in Part	I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDING
MEDIC	aliha	rimer				1 TES 2		COMPLETION OF CAUSE OF DEATH?
ME								1 YES 2 NO
ä	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF D	EATH YES	NO UNO	CERTAIN E	1		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26, I OSPITAL:	PLACE OF DEATH (Chec					
YS!		☐ Inpatient 2 ☐ ER/Outpatier	m 3 □ DOA N N	R: Irsing Home 5 A	ealdence 6 🗆	Other (Specify)		
H	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d	I. DEŞCRIBE HOW II	NJURY OCCUR	ED
B	1 Natural 5 Pending 2 Accident Investigation		M	1 YES 2	NO .			
8	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — A building, atc. (Specify)	At home, farm, street, fe	ctory, office	281.	City or Town, State)	nd Number or F	Rural Route Number,
4	29e. CERTIFIER	N: To the heat of my beauty to	4.4					
COMPLET		N: To the best of my knowledge On the basis of examination and						suse(a) and manner as et-
	29b. SIGNATURE AND TITLE OF CENTIFIER							
BE	Umna	1		29c. LIC	29		29d. DATE SI	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print)	10	1/3 2	- 2	-3/	1/75
	120 Hospital	Road, Ar	Freder	ila N	1/2	0672	Jona	than Fears
	MAR 1 4 1995 Ju	32. REGISTRAR'S SIGNATUR	IL.	•		. 1	6	



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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the foath. Page 6 may be retained by the hospital or attending physician.

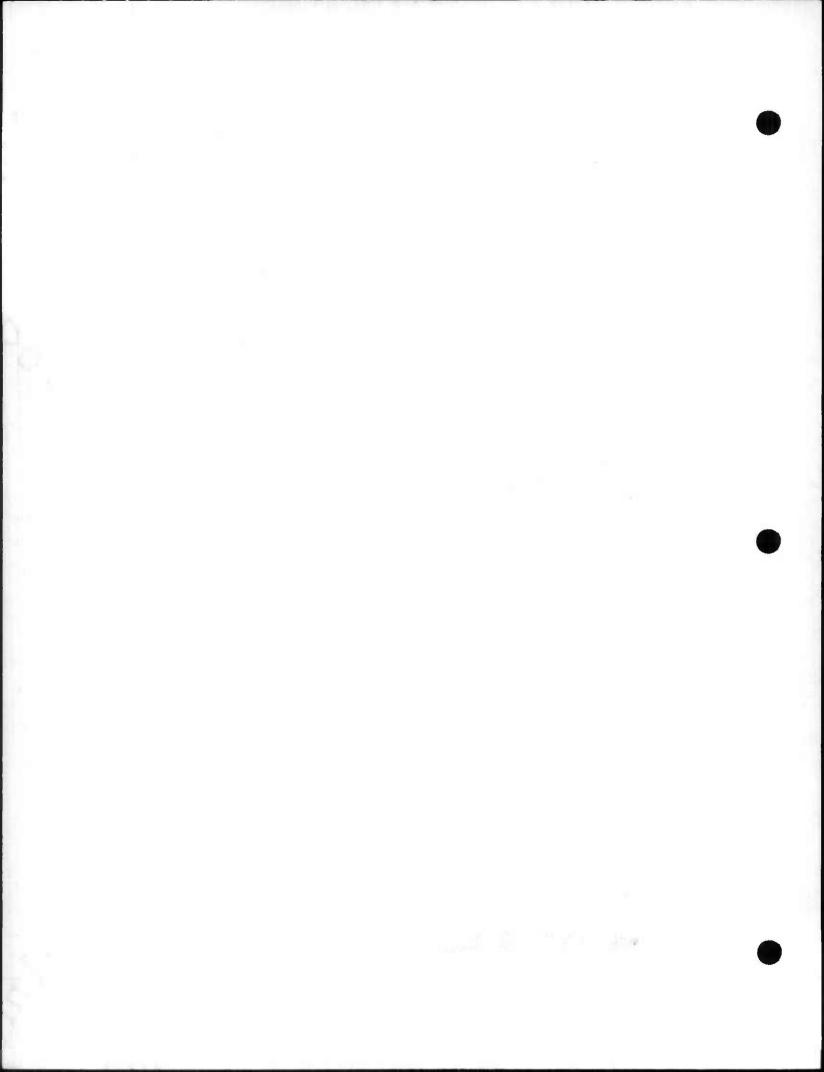
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	1100101110111			-11111	CAIL		DEAL	•	H	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	14							2. DATE OF	DEATH	γ	YEAR	3. TIME OF DEATH
	MARLY M.								MARCH		-124	1995	1:50 PM
- 1	4. SOCIAL SECURITY NUMBER		AGE (In yrs. les	st birthday)	IF UNDER 1	YEAR DAYS	IF UNDER 2	MIN.	7. DATE OF E (Month, Da	HRTH v. Year)		e. BIRTH	PLACE (State or Foreign
	215-05-8270 ¹□м² ØF 78				MONTHS	UMYS	HOURS	Marra.	AUG.3,				
~	9a. FACILITY NAME (If not institution, give st		9b. CITY, T	TOWN O	R LOCATIO	N OF OE	ATH		9c. COU	NTY OF D	EATH		
DIRECTOR	HARBOUR HOSPITAL					BA	LTIM	ORE			BA	LTIM	ORE CITY
<u> </u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			I too CITY	r, TOWN OR	LOCAT	ION					-	
Ä	MARYLAND ANNE	ARUNDEL		100.011		ERN							10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	ARONDEL			SEV	_	ZIP CODE				40 - OIT	754 05 4	1 TES 2 NO
BY FUNERAL	8141 HARVEST COUR	т				101.		144			10g. Crit		HAT COUNTRY?
N.	11. MARITAL STATUS	12. WAS DECEDENT EV	FRINITS AS	MED	42 44	LC DEC			IC ORIGIN? (S		Mar.	U.S	
正	1 Never Married 2 Married	FORCES? 1 [YES 2 X	WO	If y	yes, spe	city Cuban,	, Mexicar	, Puerto Ricar	, etc.)	or No-	Black	- American Indian, White, etc.
	3 ▼ Widowed 4 □ Divorced	IF IES, GIVE WANT	OH DATES		1 11	_ TES	2 💢 NO	Specify				Specif	WHITE
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DE	CEDENT'S	USUAL OCC	UPATIO	N.		16b. KIN	D OF BUSI	NESS/INC	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	vork done dui e retired.)	ring mos	st of working						
4	10TH GRADE		L	ABORE	R				MAJE	STIC	DIS	TILL	ARY
Ö	17. FATHER'S NAME (First, Middle, Last)						16. MOTHE	ER'S NAR	AE (First, Middle	, Meiden S	Surname)		
ш	JOHN EICHELMAN						BAI	RBAR	A GOEI	LER			
TO B	19e. INFORMANT'S NAME (Type/Print)		190	b. MAILING	ADDRESS (Street ar	nd Number o	r Rural A	oute Number, C	ity or Town,	State, Zip	Code)	
-	BARBARA ZANGHI			3141	HARVE	ST	COURT	Γ –	SEVERN	, MD	211	44	
- 1	20g. METHOO OF DISPOSITION 1 Buriel 2 Cremation 3 Remo	oval from State	20b. PLACE			ION (Ne	me of		OATE	20c. LOC	ATION -	City or Tox	vn, Stata
	4 Donation 6 Other (Specify)		NEW CA	ATHED	ERAL	CEM	ETERY	Y	3/13	BAL	TIMO	RE	
	21, SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1 -	1	22. NA HIIR	ME AN	O ADDRESS	OF FAC	L HOME	TN	C		
	1 Vallah		lux		410	7 W	TLKEN	VS A	VENUE	- BA	о. І.ТТМ	ORE	MD 21229
	23. PART I. Whiter the diseases, or o	complications that ca	used the de	eth. Do n									Approximate
	anock, or naert failura.	List only ona cause	on aach iina				in more in				,		Interval Between
	iMMEDIATE CAUSE (Final disease or condition	10000		JEL DEARCTION SEQUENCE OF:					Onset and Death				
	resulting In dasth)	DUE TO (OR	AS A CONSEC	DUENCE OF	UPPRICE I	ILOY	1						3 DAYS
-													1 DAY
CERTIFICATION	Sequentially ilst conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEC	DUENCE OF):								1
3	cause. Enter UNDERLYING	ATT	AS A CONSEC	MSci	ILAN	Dis	SASE						YRS
E	CAUSE (Disesse or Injury that initiated events				,								
E	resulting in death) LAST	ı <i>F</i>	+164	BLOD	0 6	435	UNE						YNS
	PART II. Other aignificant conditions	s contributing to dea	th but not n	esuitina l	n the unde	riving	cause als	ven in f	Dant I Dan	WAS AN A	ITTORAN	Lan	
EDICAL		CHON						ven m r		PERFORM	ED?	- 1	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
		CF-0010	10 100	70710	FPITCE	7/66			10	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
Σ	DID TOPACCO LISE CONTR	MINISTE TO CALIC	F OF DEA	TII VE	C 🗆 N		/1110	D=4.15					1 TYES 2 NO
A I	DID TOBACCO USE CONTR	GBUTE TO CAUS			H (Check only		UNCE	KIAIN					
2	EXAMINER?	HOSPITAL:	A		OTHER:		111						
PHYSICIAN:	27. MANNEB OF DEATH	1 2 Inpatient 2 ☐ ER/			7			-	Other (Spe				
	1 Natural 5 Pending	(Month, Day, Ye		26b. TIME INJU	JRY	WOF	RK?		26d. DESCRIB	E HOW IN.	JURY OCC	CURED	
B₹	2 Accident Investigation	HIDV As been	- 4		1 Y	ES 2 🗌	\rightarrow						
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF IN. building, atc.	(Specify)	me, rerm, e	ireet, factory	, offica			261. LOCATION City or Tox	l (Street an vn, State)	d Number	or Rural Ro	oute Number,
L	2014 CERTIFIED												
3 Suicide 4 Homicide 6 Could not be detarmined building, etc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.													
ō l	2 MEDICAL EXAMINER: On the besid of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.							and manner as stated.					
шШ	296 SIGNATURE AND TITLE OF DERTIFIER	0	1				29c. LICEN	SE NUMI	BER		29d. DAT	E SIGNED (Month, Day, Year)
면 인	serail M Lond	ew) at	tendy	Bly	sician		02	920	6		M	ALCH	9th, 1995
	30. NAME AND ADDRESS OF PERSON WHO								^				
	GERARDM COWD	1, M.D.	HAM	on 1	Hospi	ML	CENT	zu.	300	(5.	HAND	well s'	T BALT, MD
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE										212
	MAR 1 4 1995	Jali day	den Ro	al. Il									



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	I	tem1,Film721,3/	/14/95,lt						9	5 0/030	
		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR	TMENT 0	F HEALTH AND OF DEATH	MENTAL HYGIEN			
. 1		1. DECEDENT'S NAME (First, Middle, Last)	1 - 21	_				2. DATE OF DEATN	:	3. TIME OF DEATN	
		Sarah F	ah Sadie] <i>- Knop</i>	Fran	nces Knopp Knop				199		
		4. SOCIAL SECURITY NUMBER		(In yrs. last	birthday)	IF UNDER 1 YE	EAR IF UNDER 24 HRS.	7. DATE OF BIRTN		BIRTHPLACE (State or Foreign	
20		212-05-4081	1 🗆 M 2 💢 F	92	YRS.	MONTHS DA	AYS HOURS MIN.	Aug. 9,19	02	MARYLAND	
physician. bunal-transit permit. Pages 1, 2, 3 should	OR	9e. FACILITY NAME (If not institution, give s Stella M.	treet and number) aris Hospice		9b. CITY, TOWN OR LOCATION OF DEA			PEATN		Y OF DEATH LTIMORE	
£.	ַל	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY									
Page	DIRECTOR		TIMORE		10c. CIT	v, town or L TOWSO				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
permi	1AL	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE	10g. CITIZEN OF WHAT COUNTRY?		
ian. -transit	FUNERAL	2300 D	ulaney Valle				21204		USA		
	ВУ	1 Never Married 2 Merried 3 XVIdowed 4 Divorced	FORCES? 1 YES	2 2 N	MED O	It yes	s, specify Cuban, Maxic YES 2 NO Speci		or No — 14	Specify: WHITE	
r attending use as the	ED	15. DECEDENT'S EDUC	CATION	16a. DEC	EDENT'S	USUAL OCCU	PATION	16b. KIND OF BUS	SINESS/INDUS		
50	COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 1.2	College (1-4 or 5+)	(Giv	Do NOT us	vork done durin e retired.) usewif	g most of working	Own H			
8 & 6		17. FATHER'S NAME (First, Middle, Lest)	,			191	AME (First, Middle, Meiden ry Wolfe	Surname)			
s retained 5 should notified	TO BE	19e. INFORMANT'S NAME (Type/Print) Debra Ann Moy		19b.				Route Number, City or Town			
e 6 may be ector, page must be		20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)			ND DATE (F DISPOSITIO		9 ATE 20c. LO	CATION - CIN	y or Town, Stata	
toneral dir toneral dir xaminer	1	22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093									
within a4 hours at appletely filled in by cremation, or removent, the medical		23. PART I. Enter the diseases; or cahock, Dr heert feilure. IMMEDIATE CAUSE (Final disease Dr condition resulting in deeth)	Emplicationa that cause List pnly one cause on a	each line.	h	ot enter the	mode of dying, suc	ch ss cerdiec or reepi	ratory arres		
and and harting	TION	Sequentially list conditions, if any, leading to immediate	bDUE TO (OR AS	A CONSEO	UENCE OF		- Sec				
h certificat ending phy Hygiene p or other	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
5 8 5 E	- 1	PART ii. Other significent condition	s contributing to deeth i	but not re	suiting i	n the under	lying ceuse given in	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
w requires that the been signed by the pt. of Health and 1 shows any In	MEDICAL	Lengoshor Me	Sept feel	lov4)		1 TYES 2		COMPLETION OF CAUSE OF DEATH?	
rSiGian: The law req certificate has been th the State Dept. of d, or Item 23 sho		DID TOBACCO USE CONTI	RIBUTE TO CAUSE C			S 🗆 NO		N 🗆		TES 2 NO	
N: The ficate has State D	ठ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	N (Check only	one)				
ictan: sertifica the Sta	YS!	1 🗆 YES 2 📉 NO	1 Inpetient 3 ER/Out	patient	DOA	OTHER:	Nome 5 - Reeldence	8 Other (Specify)			
王 莊 孝 名	Y PHYSICIAN:	27. MANNER OF DEATN Netural 5 Pending Accident Investigation	28s. DATE OF INJURY (Morth, Day Year)		266, TIME INJ	JPTY	INJURY AT WORK?	28d. DESCRIBE NOW II	NJURY OCCUP	RED	
TOR: A after d after d 28 Is	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	26e. PLACE OF INJURY building, etc.//Spe	Y — Al hom	ne, tarm, s			28f. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,	
OR A DIREC hours		29a. CERTIFIER							_		
A Z =	COMPL	(Check only	CIAN: To the best of my known. R: On the basis of examination							euse(e) end manner ee stated.	
포 포 를 O	BEC	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NU		29d. DATE S	IGNED (Month, Day, Year)	
2 6 8 ₹	2	30 NAME AND ADDRESS OF PERSON WHO	O COMPLETED OFFICE						7/	2	

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STITTE OF SIGNATURE

31. DATE FILED WAR 1 4 1995

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a burns after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

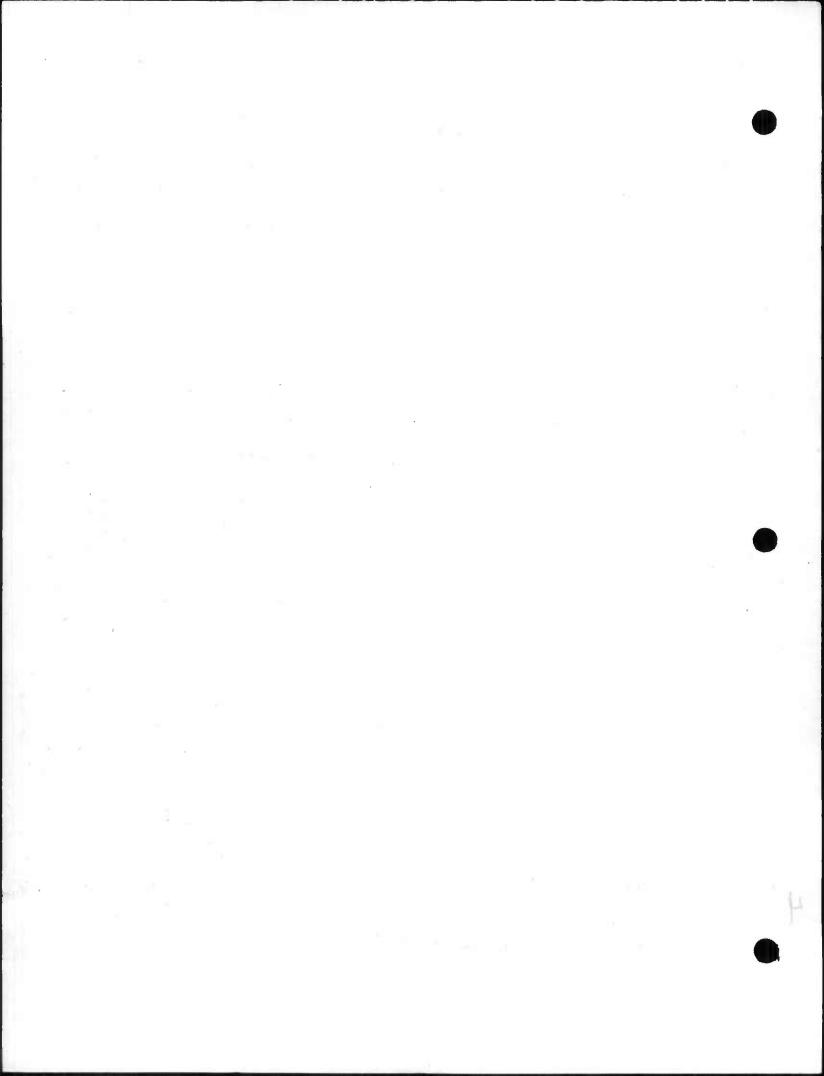
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

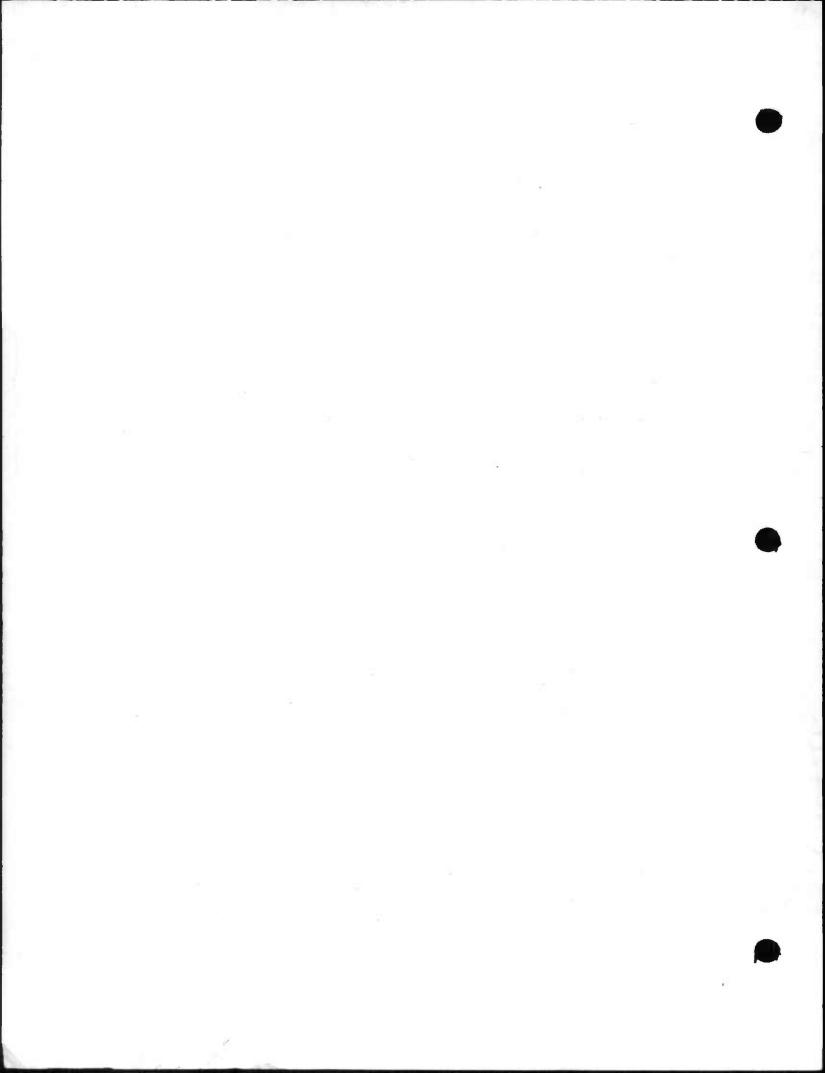
REG NO.

_								HEG. NO			
	1. DECEDENT'S NAME (First, Middle							2. DATE OF DEATH MONTH D	W 1.C	XEAR	3. TIME OF DEATH
	Andrew E	Edward Ke	11ner 6. AGE (In yrs. last	histoday	UNDER 1 YEAR	IF IMPER		March 11	, 19	955	0017/
	218-36-3699		5.5		NTHS DAYS		MIN.	7. DATE OF BIRTH (Month, Day, Year)	020	Country	· _
	9a. FACILITY NAME (If not institution			98	b. CITY, TOWI	OR LOCATI	ON OF DE	Oct.14,1		NTY OF DE	aryland
OR		North Poi	nt Road	d E	D	undal	Lk			Ba1	timore
DIRECTOR	RESIDENCE OF DECEDER	OUNTY		10c, CITY, T	OWN OR LOC	ATION					10d, INSIDE CITY
DIR	Md.	Baltimor	е				Dun	ıda1k			LIMITS?
AL	10e. STREET AND NUMBER					10f. ZIP COD	E		10g. CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	3221 Old N	North Poin	t Road				212	22		US	A J
5	11. MARITAL STATUS (X) Never Married 2 Married	FORCES? 1	T EVER IN U.S. ARI		13. WAS D	ECENDENT C	F HISPAN	IIC ORIGIN? (Specify Yes	or No-	14. RACE Black	— American Indian, White, atc.
В	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆 Y	ES 2 🔀 NO	Specify			Specif	White
G	15. DECEDENT (Specify only highes	'S EDUCATION st grade completed)	18a. DE0	CEDENT'S USI	UAL OCCUPA	TION	30	16b. KIND OF BUS	SINESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5 +	·)	Do NOT use re	rtired.)		10	n/			- 1
COMPLETED	9th 17. FATHER'S NAME (First, Middle, Li	- cott		Disab	ilit						
		B. Kellne	r			18. MOTI	Mary	ME (First, Middle, Maiden Zorn	Sumame)		
) BE	19a. INFORMANT'S NAME (Type/Prin	nt)	19b	. MAILING AD	DRESS (Street	t and Number	or Rural I	Route Number, City or Tow	n, State, Zip	Code)	
5	Louis Kell	lner	7.	416 0	ld B	att1	e Gr	ove Road	Bal	Ltim	ore MD.212
	20a. METHOD OF DISPOSITION 1 Deurlai 2 Cremation 3			ND DATE OF D		Name of		DATE 20c. LO	CATION —	City or Tox	vn, State
	4 ☐ Donation 5 ☐ Other (Specify 21. SIGNATURE OF FUNERAL SERV				Ceme	tery		5/95 Ba	ltin	nore	MD.
	· R T	//	1	1				neral Hom	e of	E Es	sex
	22 PART I Enter the disease	m (s	mell	11	300	Mace	2 A T	re. Balti	more	MD =	
		illure: List only one cau	aa on aech ilpe	stn. JUB not	ontar tha n	noda ot dy	ing, suci	h as cardiac or raapi	ratory arr	aat,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	'	Ca	ncer	-						Onset and Death
ı	resulting in death)	DUE TO	(OR AS A CONSEO								
N	Sequentially list conditions,	C b									
ATI	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSEO	UENCE OF):							
CERTIFICATION	CAUSE (Disease or Injury thet initiated evants	c. DUE TO	(OR AS A CONSEO	UENCE OF):							-
EH	resulting in death) LAST	d									
	PART II. Other aignificant con	nditions contributing to	death but not re	eaulting in t	ha underly	ng cause g	givan in	Part I. 24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL	Chron	nic Alcoho	lism					PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC											DF DEATH?
											^
PHYSICIAN:	25. WAS CASE REFERRED TO MEDI- EXAMINER?	HOSPITAL:	C=-0AT-0.1	0	28. THER:	PLACE OF D	EATH (Che	ack only one)			
HYS	1 YES 2 NO	1 Inpatient 2 28a. DATE OF		DOA 4 (NJURY AT	sidenca	8 Other (Specify) +	one		
	1 Netural 5 Pending	(Month, Di		INJURY	/ · · · · · ·	VORK?	NO	200. DESCRIBE NOW II	NJUNT OCC	JUNED	
D BY	2 Accident Investig 3 Suicide S Could r	28a. PLACE O	F INJURY — At horate, (Specify)	ne, farm, atrea	nt, factory, of	lica		281. LOCATION (Street a City or Town, State)	nd Number	or Rural Ro	oute Number,
	4 Homicide datarmi	ned	artic (Opecny)					City or lown, Stelle)			
COMPLETED	29a. CERTIFIER (Check only	PHYSICIAN: To the best of	my knowledge, das	th occurred a	t the time, de	its and place	and dua	to the cause(s) and man	ner as atat	ed.	
Š	one) 2 MEDICAL EX	(AMINER: On the basis of ax	camination and/or in	vestigation, in	n my opinion	daeth occur	ed at the	time, data and placa, an	d due to th	a cause(s)	and manner as atated.
BE	29b. SIGNATURE AND TITLE OF CE	RTIFIER O				29c. LICE	NSE NUM	IBER	29d. DATE	E SIGNED	(Month, Day, Year)
ဝ	Vennis	J. Chute	m				.C.	M.E.	M	ARCI	H 14, 1995
	30. NAME AND ADDRESS OF PERSO										21221
	31. DATE FILED (Month, Day, Year)	32. BEGISTRA	R'S SIGNATURE	PENN	STRE	ET E	BALT	IMORE, M	ARYL	AND	21201
	MAR 1 4 1	995 Julia	Avilson Ran	delle							
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		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN	_		
	- {	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA		3.	TIME OF DEATH
		John Walter Ko					Mar 12	1995		7.30 PM
		055 45 4555	5. SEX 6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 17	0	Country)	stria
3 should	Œ.	9a. FACILITY NAME (If not institution, give street 3701 A Internation)		#717	96. CITY, TOWN O	or LOCATION OF DE	HTA	9c. COUNTY	OF DEAT	н
1, 2,	5	RESIDENCE OF DECEDENT						1	5	
physician. burial-transit permit. Pages 1, 2, 3 should	DIRECTOR	Md Monto	gomery	1	y, town or local Lver Sp				1000	d. INSIDE CITY LIMITS? X YES 2 \(\square\) NO
it permi	FUNERAL	100. STREET AND NUMBER 3701 A Internat	ional Dr	#717	10	1. ZIP CODE 20900		10g. CITIZEN USA		
physician. burial-trans	S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC		IIC ORIGIN? (Specify Yes		RACE —	American Indian,
ling phys the buria	BY F	1 Never Married 2 X Xarried 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, sp	ecify Cuben, Mexice 2 NO Specify	n, Puarto Rican, etc.)		Specify: hit	hita, atc.
or attending r use as the	밀	15. DECEDENT'S EDUCA (Specify only highest grade of		(Give kind of	USUAL OCCUPATION	ON ost of working	16b. KIND OF BUS			
oital or	COMPLETED	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Enter	se retired.)		mb oo t			
the hospital detached for	OM	17. FATHER'S NAME (First, Middle, Last)	2yrs	Biledi		18. MOTHER'S NA	Theat ME (First, Middle, Maiden			
d be d	BE C	Sigmund Koliso	ch			Matil		,		
retained by the hospital or 5 should be detached for notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print) Susan Sonde		19b. MAILING 2011	St. St	end Number or Rural F	Noute Number, City or Tow. Woods Dr	Cr	own	sville
beath. Page 6 may be funeral director, page xaminer must be r		20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	val trom Stata 20b	PLACE AND DATE	OF DISPOSITION (Na	ame of	DATE 20c. LO	CATION — City	or Town,	21032 Stata
Page 6 al directo ner mu		21, SIGNATURE OF FUNERAL SERVICE LICE	HSEE, //	neseth	Israel 22. NAME AI	Cemete	An CHUTY	napol	is	Md
43 -: 49		· Valt Jahr	41		Rida	elv Ave	neral Ho	olis.	Md	
hours after of ed in by the i or removal.		23. PART i. Enter the diseases, or co ahock, or least failure. Li	mplications that caused ist only one cause on e	the death. Do a	not enter the mo	ode of dying, such	n ss cardiac or respi	rstory arrest,		Approximata interval Between
# 6 ±		IMMEDIATE CAUSE (Final disease or condition resulting in death)	met a of	alie	· Co	lon	Cance	Z		Onset and Death
con tal,	z		DUE TO (OR AS A	CONSEQUENCE O	F):					,
be estored cian a for to	ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):					
ertificating phy giene giene gother	CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
attendi	CER	d.								
T April	AL	PART ii. Other significant conditions	- / [/ ·	/		1 11-			AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO
두 모드 등	EDIC	4710 4	o Condion	NYEPN	my 2	to MIT	1 NES 2	E) NO	OF	MPLETION OF CAUSE DEATH?
w requires been sign pt. of Heal 3 shows	N.	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YE	S NO L	UNCERTAIN	<u> </u>	1	1	YES 2 NO
PHYSICIAN: The law req this certificate has been with the State Oept. of rked, or item 23 sho	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one) OTHER:					
CIAN: certification the St	HYSI	1 YES 2 INO	1 Inpetient 2 ER/Outp	etlent 3 DOA	4 - Nursing Hom	ne 5 Residenca				
OING PHYS After this of death with s marked,	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		URY WO	URY AT DRK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURE	D	
TTENOI TOR: A after d	ED	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, (straet, tactory, offic	•	28f. LOCATION (Street a City or Town, State)	and Number or Ri	ural Route	Number,
# 25 F	COMPLET	onel	AN: To the best of my knowl						usafa) an	d manner se stated.
13 電影 岩	BE C	296. SIGNATURE AND TILE OF CENTIFIER	Rat	1/2	111	29c. LICENSE NUM	IBER	29d. DATE SIG	NED (Mo	onth, Day, Year)
P P 2 X	2	30. NAME AND ADDRESS OF PENSON WHO	COMPLETED CAUSE OF DE	NTH (ITEM 27) (Type	Print)	131	478	. 1 7	1 6	7175
2		Harbor fame 31. DATE FILED (Month, Day, Year)	Ly Clenic	190	O DON	NAHO	mover)	ND	AU	D MH
0		MAK 1 4 1995 0	Mar on monday, and							11225



rector, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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2	PHYSICIAN: 1
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	OSPITAL

TO THE HOSPITAL OR APPROADE THE LINE INVESTIGATE THE LINE requires that the death certificate be executed within Jours after death. Page 6 may be retained by the host	TO THE FUNEFAL DIRECTION And THE CONTROL HE SET SECTION OF SET SET SET SET SET SET SET SET SET SET	be filed within 72 hours and press that the State Energy of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il then 28 is marked, or teem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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1.	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
_	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

					OAIL	OI.	DEAL		н	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) AGNES	SAMES			2		_	- 1.	2. DATE OF E	DEATH DA	7, 19	9.45°	3. TIME OF DEATH 2:03AM
	4. SOCIAL SECURITY NUMBER 213-60-3025	5. SEX 6. /		GE (In yrs. last birthday) IF I			VS HOUDS MIN		7. DATE OF B (Month, Day	(Year)		Countr	PLACE (State or Foreign
	9a. FACILITY NAME (if not institution, give street and number)												
Œ	4						R LOCATIO STON	N OF DEA	тн			NTY OF DI	EATH
DIRECTOR	Fallston General Hospital					3118	con				пат	ford	
H.	10s. STATE 10b. COUNTY				Y, TOWN OF								10d. INSIDE CITY LIMITS?
		imore		Kı	ngsv:	1116							1 TES 2 NO
RAL	100. STREET AND NUMBER 11403 Cedar Lane					101	ZIP CODE	087					HAT COUNTRY?
FUNERAL	11.405 Cedal Lane	40 1400 050505117 511			1							S.A.	
	1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1	res 2	RMED NO	1 16	yes, spi	ecity Cuban	, Maxican,	ORIGIN? (Sp Puerto Rican	etc.)	or No —	14. RACE Black	— American Indian, , White, atc.
A	3 🕅 Widowed 4 🔲 Divorced	IF YES, GIVE WAR (OR DATES		1	_ YES	2X/NO	Specify:				Spec# Whi	te
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION Completed)	16a. DE	CEDENT'S	USUAL OC	CUPATIO	N st of working	,	16b, KJN	D OF BUS	INESS/INI	-	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	. Do NOT us	a retired.)		ot or working	,	- ,				
MP	12 4 17. FATHER'S NAME (First, Middle, Last)	-	Sch	ool T	each	er				catio			
8	William Baldy Jan	nes					100		E (First, Middle Marti				
BE	19a. INFORMANT'S NAME (Type/Print)		19	h MAILING	Annosee	(Steed B			ute Number, C			- 0	
5	Barbara Kerr Howe	<u> </u>	1	1403	Ceda:	r La	ane	Kin	gsvill	le, N	lary.	land	21087
	20s. METHOD OF DISPOSITION 1	oval from State	20b. PLACE	AND DATE C	of Disposit	TION (Na	me of		DATE /9/95			City or Ton	
	21. SIGNATURE OF FUNERAL SERVICE LIC		Dotai	ley va			ID ADDRESS			100	VSUII	,Mary	Tanu
	+ E7 Lan	n hu			ΙE.	F.	Lass	ahn	Funera				. 04007
	23. PART I. Entar the diseases, or o	omplications that car	Used the da	sth. Dp n	Dt anter t	/ OU ha mo	ge of dylu	IT K	as cardiac	or reapir	SVII.	Le, MC	.21087
	ahock, or haart fallura. I IMMEDIATE CAUSE (Final	_lat D⊓iv ona cause d	n aach line										Internal Setucion
ŀ	disesse or condition a CONG ESTIVE HEART FAILURE Edger Aut That												
ı	IMMEDIATE CAUSE (Final disease Dr condition resulting in death) a. CONGESTIVE HEART FAILURE CAYSTANTMA TUX DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											11.4	
NO NO	Sequentially list conditions,	1 YOCAL	diA/	LN	FARC	110	N						Jul
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	()1058	A S . S	COENCE OF);								2 days
티	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSE	OUENCE OF	7):								1 2 2 3
#	resulting in death) LAST	l											
	PART II. Other significant conditions	contributing to dea	th but not i	resulting I	n the und	larivino	Cause of	ven le Pr	art I 24a	WAS AN A	UTOBev		WERE AUTOPSY FINDINGS
EDICAL				and the same		ider y reng	causa gi	ven in re		PERFORI	MED?	240.	AWAILABLE PRIOR TO COMPLETION OF CAUSE
ED									_ 1 [YES 2	740		OF DEATH?
Σ	DID TOBACCO USE CONTR	PIBUTE TO CAUSE	OF DEA	TH YE	ςΠи	OX	LINCE	RTAIN					1 TYES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT	_		OITCL	KIMIN					
Sic	EXAMINER?	NOSPITAL:	Outpatient 3	□ DOA	OTHER:		5 🗆 Res	Idence 6	☐ Other (Spe	ecify)			
Y PHYSICIAN	27. MANNER OF DEATH 1 Natural 5 Pending	26e, DATE OF INJU (Month, Day, Ye		26b. TIMI	OF 2	6c. INJU	JRY AT	2	28d. DESCRIB		JURY OC	CURED	
May 1	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJ building, atc.	URY — At ho	ome, farm, s	treet, factor				28t. LOCATION City or Tox	l (Street ar	nd Number	r or Aural A	oute Number,
						_							
COMPLETED	(Check only	BAN: To the best of my last on the best of examination											and manner as stated.
8	296. SIGNATURE AND TITLE OF CERTIFIER	mu_					29c. LICEN	SE NUMB	ER 19		29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITE	M 27) (Typ).	Print)	11	10	- G	plle	<u></u>	6	HICH	2010 bl
	31. DATE FILED (Month, Day, Year) MAR 1 4 1995	32 REGISTRAR'S	SHATURE CARLE			- 0				12	0,0	n. '	03/700
	000		4										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dect. of Health and Memtal Hydiene prior to brinal cremation, or removal BALTIMORE, MARYLAND 21215-0020

4

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

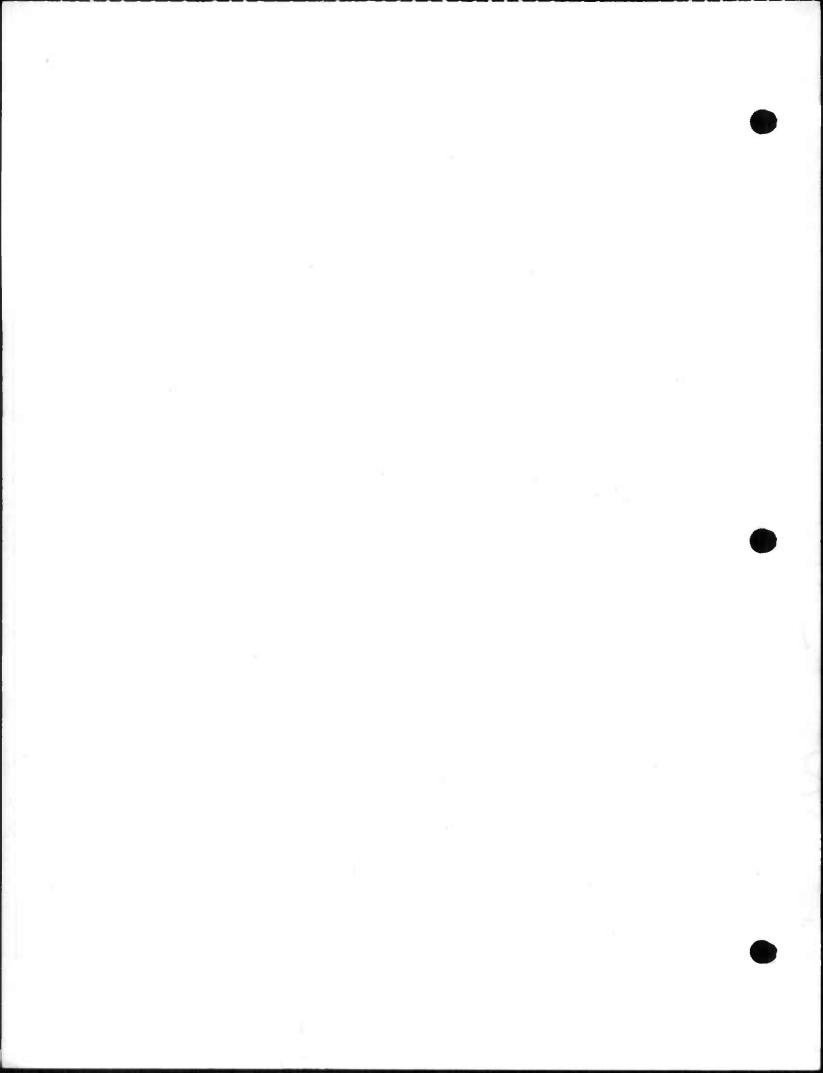
		REGISTRAR		CERTIF	ICATE (OF DEATH	REG. NO					
		1. DECEDENT'S NAME (First, Middle, Last)	1 . 1 .				2. DATE OF DEATH		3. TIME OF DEATN			
		George	Lichter				MONTH	7. 194	EAR DR: 40 A.			
ļ		4. SOCIAL SECURITY NUMBER		in yrs. lest birthday)	IF UNDER 1 Y	EAR IF UNDER 24 HRS.	7. DATE OF BIRTH					
		214-18-1265	1 X M 2 □ F 72			YS HOURS MIN.	(Month, Day, Yeer)		BIRTNPLACE (State or Foreign Country)			
		9a. FACILITY NAME (If not institution, give s	/	1110.			MAY 3, 19	22	NEW YORK			
	· ~		treet and number)			WN OR LOCATION OF DE	ATN	9c. COUNTY N/A	OF DEATH			
	DIRECTOR	SINAI HOSPITAL			BALI	IMORE		IN/ A				
	[ឆ្ជ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	10.00								
	🖺	MARYLAND N/A/			TIMORE				10d. INSIDE CITY LIMITS?			
				DAL	THORE				YES 2 NO			
	ERAL	10e. STREET AND NUMBER				10f. ZIP CODE			N OF WHAT COUNTRY?			
	<u></u>	2128 WESTERN RUN	DR.			21209		USA				
	FUN	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS	DECENDENT OF NISPAN	IIC ORIGIN? (Specify Yes	or No- 14	. RACE — American Indian,			
		1 Never Married 2 Merried	FORCES? 1, YES	2 NO		s, specify Cuban, Maxical YES TO NO Specify			Black, White, alc.			
1	ВУ	3 Widowed 4 Divorced	WWII			X No specify		V	VHITE			
- 1	8	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	USUAL OCCU	PATION	16b, KIND OF BU	SINESS/INDUS	TRY			
		(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT us	work done durin	g most of working						
	7	Lientenary (0-12)	College (1-4 or 5+) 5+	PHARMAC	IST		MEDICIN	ie				
69	COMPL	17. FATHER'S NAME (First, Middle, Last)				1						
at once		LEIB LICHI	'ER			IDA	ME (First, Middle, Malden	Surneme)	KELROD			
9	B		.DIX									
notified	2	19e. INFORMANT'S NAME (Type/Print)	TODO	19b. MAILING	ADDRESS (St	reat end Number or Rural F	Soute Number, City or Tow	n, State, Zip Co	de)			
9		MRS. ROSALIE LICH	TER	2128	WESTER	N RUN DR.	BALTO., N	ID 212	209			
문		.20a. METHOD OF DISPOSITION A.A. Buriel 2 Cremetion 3 Reme		PLACEANDDATE		N (Name of	DATE 20c. LO	CATION City	or Town, State			
E		4 Donation 5 Other (Specify)		etery, cremetory or o	ther place) CHEBRE	W 3/9/199	5 RE	STERS	POWN, MD			
or other traumatic event, the medical examiner must be		21. SIGHATUBE BY FUNERAL SERVICE LIC		731111010		E AND ADDRESS OF FAC						
E		▶ (/// ₂	70. 1		SOL	LEVINSON &	BROS., IN	IC.				
6	_	Ley Wall	Delle	day.	6010	REISTERTO	WN RD. BA	ALTOII,	MD 21215			
8		23. PART I Enter the diseases, or shoot or heart failure	complications that caused List only one ceuse on e	the death. Do	not enter the	mode of dying, auch	as cardiac or resp	retory arrest				
E	1		cast only one cause on el	ech line.					Onset and Death			
£		IMMEDIATE CAUSE (Final disease or condition resulting in death) A cute Myocardial Infarction Iday Due TO (OR AS A CONSEQUENCE OF):										
ent,		resulting in death)	DUE TO OR AS A	CONSECUENCE OF	Largi	al Inta	YCHON		1 day			
3	1			CONSECUÇÃNCE O								
Ter.	CERTIFICATION	Sequentially flat conditions,	b	CONSEQUENCE O								
ne	AT	If any, leading to immediate couse. Enter UNDERLYING	DOL TO TON AS A	CONSEQUENCE OF	r _] ,							
10	5	CAUSE (Disease or Injury	C. DUE TO (OR AD A	00110501151105								
5	Ē	thet initiated events resulting in death) LAST	DOE TO (OR AS A	CONSEQUENCE O	r):							
	H	d										
any injury,		PART II. Other significent condition	s contributing to death be	ut not resulting	in the under	Ving cause given in	Part I. 24e. WAS AN	ALITODEV	OSE WERE ALTROPOL ENGINEE			
-	EDICAL	Hypertensi				ying couse given in	PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
8 3	ă	ilyper lensi	on; Coron	ary Ar	Tery !	lisease	1 _ YES 2	NO	COMPLETION OF CAUSE OF DEATH?			
shows	Z						_		1 TES 2 NO			
23 \$		DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YE	S 🗆 NO	UNCERTAIN	1 🗆		^			
E 2	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT								
or Item	Sic	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp.	etlent 3 🗆 DOA	OTHER:	Home 5 Residence	e C Other (Counts)					
	PHY	27. MANNER OF DEATN	280. DATE OF INJURY	28b, TIM		INJURY AT	26d. DESCRIBE NOW I	N.HIBY COOLS	ED			
marked,		1 Natural 5 Pending	(Month, Day, Year)		URY	WORK?	200. DESCRIBE NOW I	NJOHY OCCUR	ED .			
	BY	2 Accident Investigation	20- 01 405 05 14 1100	40.5								
8		3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, atc. (Spec	At home, farm, (streel, factory,	office	26f. LOCATION (Street a City or Town, State)	and Number or I	Pural Route Number,			
m 28	E .	- Continuited										
Hem	MPL	290. CERTIFIER (Check only	CIAN: To the best of my knowl	edge, death occurre	ed at the time,	date end place, end due	to the cause(e) end mer	ner ee stated.				
MPORTANT: #	OM		R: On the basie of exemination						Juse(e) and menner se stated.			
TAN	O	296. SIGNATURE AND TITLE OF CERTIFIER										
9	H	VI 1 1	in the	D- 1-1	DI	29c. LICENSE NUM		29d. DATE SI	GNED (Month, Day, Year)			
=	2	20 HAME THE ADDRESS OF ASSESSED	MARY , //)	residen	/ hysici	AS240432	1-767836	/Vla	rch 7, 1995			
		30. NAME AND ADDRESS OF PERSON WHO	CAUSE OF DEA	ATH (ITEM 27) (Type,	Print)	11 1						
		John M. LI	PPEYT, MA	111 5	inai	Mospital						
		MAR 1 4 1995	1 38/1 EDISTADES BANK	NO RE								
		WHK T = 1999										
-												

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

. DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Part of Health and Mental Hyrilene prior to burial premation or removal	APORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSI	TO THE FUNERAL DIRECTOR: After this certific be filed within 72 hours after death with the 5	IMPORTANT: If Item 28 is marke

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND	/ DEPARTM				HYGIENE BEG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATN		3. TIME OF DEATN		
	Gany Long					MONTH 3	DAY	9 4	R		
	4. SOCIAL SECURITY NUMBER 5. SI	EX 6. AGE (In yrs.	last birthday) IF	UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	8. B	IRTNPLACE (State or Foreign		
	113 00 0111	(M2□F 56	YRS.	ITHS DAYS	HOURS MIN.		- 7 9 3 8	Pe	nnsylvania		
OR	9a. FACILITY NAME (H not institution, give street an University Hospi			altim	R LOCATION OF DE Oたと	EATH	9	nA	OF OEATN		
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CITY TO	WN OR LOCAT	ION				10d. INSIDE CITY		
DIRECTOR	Maryland Howard		1.0	lumbio					1 YES 2 NO		
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE		1	0g. CITIZEN	OF WHAT COUNTRY?		
ij	5459 Half Ligh	it Garth			21045				USA		
Ę.	11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married F	MAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	ARMED		ENOENT OF NISPAN				RACE — American Indian, Black, White, atc.		
ВУ		F YES, GIVE WAR OR DATES			2 NO Specify		m, atc.,		Specify: White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade comple	eted)	(Give kind of work	done during mos		16b. KI	ND OF BUSIN	ESS/INDUSTR	TY .		
Ä		lege (1-4 or 5+)	life. Do NOT use ret				Educa	+ 1 0			
MP	12+	6	eacher	-							
	17. FATNER'S NAME (First, Middle, Last)	1			18. MOTNER'S NA						
BE	William Glenn	Long			Marth						
0	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural F						
	Mrs Majorie M.	Mayor	5459 H	alf L	ight Ga	rth,	Colum	bia,	MD 21045		
	20a. METHOD OF DISPOSITION 1		CEAND DATE OF DI crematory or other p		me of	DATE	20c. LOCAT	ION — City o	or Town, Stata		
	21. SIGNATURE OF FUNERAL SERVICE LICENSET	Ronald Was	lo Din	22. NAME AN	D AOORESS OF FA	CILITY C	tato	Anat	omy Board		
	Xx Jan 1 011 h	rela	, , , , , ,	655W	.Baltin	1070	St Ra	Pto	1021201		
	10001/11/11	uee)							1021201		
	28. PART I. Enter the disesses, or compi shock, or heert failure. List o	niy one csuse on eech i	desth. Do not e ine.	enter the mod	de of dying, auci	h as csrdled	or reapirate	ory arrest,	Approximata interval Between		
	WIMEDIATE CAUSE (Finel										
	resulting in death)	(Introcepe		matomo	١						
		DUE TO (OR AS A CON	SEOUENCE OF):								
ON	Sequentieily list conditions, b	DUE TO (OR AS A CON	PEOUENCE OF								
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DOE TO (OH AS A CON	SECUENCE OF):								
길	CAUSE (Disesse or Injury C. —	DUE TO (OR AS A CON	SECUENCE OF								
Ē	that initiated events resulting in deeth) LAST	DOL TO (OIL AS A COIL	SECOLINCE OF J.						i i		
崽	d										
AL (PART ii. Other aignificant conditions con	tributing to death but no	t resulting in th	e underlying	ceuse given in	Part I. 24	a. WAS AN AU		24b. WERE AUTOPSY FINDINGS		
							PERFORME	/	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
						_ '	☐ YES 2	NO	OF DEATH?		
Σ	DID TOBACCO USE CONTRIBU	TE TO CALISE OF D	ATH VEC	7 NO []	UNCERTAIN				1 TYES 2 NO		
AN	25. WAS CASE REFERRED TO MEDICAL		ACE OF OEATH (C		OIACERIAII	1 1			,		
Sic		SPITAL: Inpetient 2 - ER/Outpetient	ОТ	HER:				-			
2		inputient 2 En/Outpatient		28c. INJL	5 Rasidence		pecify) IBE HOW INJU	BY OCCUBE			
T		28s. OATE OF INJURY				zou. orach	IBE NOW INJU	NI OCCONE	<i>'</i>		
PHYSICIAN: MEDIC		28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	M 1 V							
ВУ РН	27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 🗆 Y		*** ! *********	DM (Over the end	Al	10		
B	27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — At building, atc. (Specify)	INJURY	M 1 🗆 Y		281. LOCATIO	DN (Street and lown, State)	Number or Ru	ral Route Number,		
B	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined	(Month, Dey, Year) 28a. PLACE OF INJURY — At building, atc. (Specify)	INJURY home, farm, atreet	M 1 TY	ES 2 NO	City or 1	own, State)	-0,73	val Route Number,		
B	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	(Month, Day, Year) 28a, PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge,	home, farm, street	M 1 Y	ES 2 NO	City or T	s) and manner	as atated.			
B	27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	(Month, Day, Year) 28a, PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge,	home, farm, street	M 1 Y	ES 2 NO	City or T	s) and manner	as atated.			
COMPLETED BY	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	(Month, Day, Year) 28a, PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge,	home, farm, street	M 1 Y	ES 2 NO and place, and due ath occured at the 29c. LICENSE NUM	City or It	s) and manner	as atated.			
BE COMPLETED BY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the control of the control of the control one)	(Month, Day, Year) 28a, PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge,	home, farm, street	M 1 Y	ES 2 NO	City or It	s) and manner	as stated. us to the cau	se(s) and manner as stated.		
COMPLETED BY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the control of the control of the control one)	(Month, Day, Year) 28e, PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge, the basis of examination and/	home, farm, atreet death occurred at or Investigation, in	M 1 V, factory, office	ES 2 NO and place, and due ath occured at the 29c. LICENSE NUM	City or It	s) and manner	as stated. us to the cau	se(s) and manner as stated. NED (Month, Day, Year)		
BE COMPLETED BY	27. MANNER OF DEATH 1. Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 129b. SIGNATURE AND THE OCERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COM	(Month, Day, Year) 28e, PLACE OF INJURY — At building, etc. (Specify) To the best of my knowledge, the basis of examination and/	home, farm, street death occurred at or investigation, in	M 1 V, factory, office	ES 2 NO and place, and due ath occured at the 29c. LICENSE NUM	City or It	s) and manner	as stated. us to the cau	se(s) and manner as stated. NED (Month, Day, Year)		



death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buna-transit permit. Pages 1, 2, 3 should my hygiene prior to bunal, cremation, or removal.

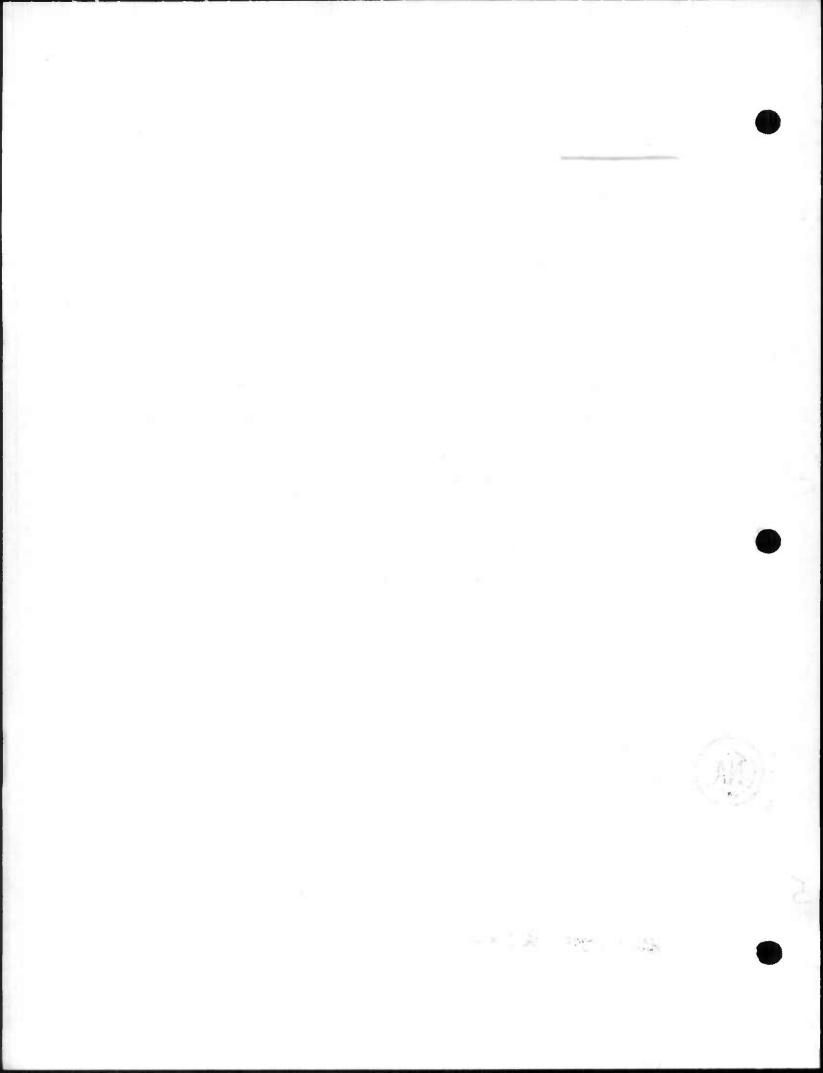
The of other traumatic event the mandreal presentance. BALTIMORE, MARYLAND 21215-0020

, P.O. BOX 68760

WITAL RECORDS	The aw requires that the d	the has been signed by the	Sale Dept. of Health and Mer	The last opposite the last
DIVIDIONO	TO THE HOSPITAL OR ATTEMPTS	TO THE FUNERAL DIFFECTION OF THE PARTY.	be filed within 72 hours at the same	DEPOSITE OF STREET, ST. STREET

N ... i

Item	# 4 Film # G 721 3-14-9	J Hene I CI I		11000					0	0 1 0 -1 -	
	1 - STATE REGISTRAR	STATE OF MARY	YLAND C	DEPARTI	MENT OF	HEALTH AND	MEN	TAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest)	egendre					2. D.	ATE OF DEATH DA	Ö 7	YEAR 17/8 M	
	4. SOCIAL SECURITY NUMBER 9a. FACILITY NAME (If not institution, give st	1 🗆 M 2 📈 F	GE (In yrs. le	YRS.	F UNDER 1 YEAR ONTHS DAYS	DAYS HOURS MIN. (Morth, Day, Year)			1905	8. BIRTHPLACE (State or Foreign Country) CANADA	
DIRECTOR	HARBOR HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH N/A		
EC.	10a. STATE 10b. COUNTY			10c. CITY, 1	TOWN OR LOCA	ATION				10d. INSIDE CITY	
	MARYLAND BAI	LTIMORE		I	UNDAL	Of, ZIP CODE			40. 0000	LIMITS? 1 YES 2 XNO	
FUNERAL	64 BROADSHIP ROA	\D			1 "	21222				EN OF WHAT COUNTRY?	
S	11. MARITAL STATUS	12. WAS DECEDENT EVE			13. WAS DE	ZIZZZ CENDENT OF HISPA		IGIN? (Specify Yea		U.S.A.	
B✓	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	R DATES		If yes, a	specify Cuban, Mexico S 2X NO Specif	an, Puer	rto Rican, etc.)		Specify: WHITE	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) Coffege (1-4 or 5+)	(G	ECEDENT'S US Give kind of work b. Do NOT use n	k done during m etired.)	TION nost of working		16b. KIND OF BUS			
N N	17. FATHER'S NAME (First, Middle, Lest)		Н	IOMEMAK	ER				N HOM	<u>E</u>	
BE CC	THEOSPHORE CA	YER				BELZE	MER	E CROTE	AU		
2	19e. INFORMANT'S NAME (Type/Print)					and Number or Rural					
2	DENIS LEGENDRE	1,		30/ FU						MD. 21061	
	20a, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ramo 4 Donation 5 Other (Specify)		cemetery, cre	ematory or other	nlace!	JESUS 3-1	1			Ity or Town, Stata	
	21. SIGNATURE OF FUNERAL SERVICE LICE		DACKE	D HEAR		AND ADDRESS OF FA			JALK,	MARYLAND	
2	+ Halles x	Hart			2134	EY-ASHTO WILLOW S	PRI	UNERAL H	BALT	. MD. 21222	
2	23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) S. Cardiac Arrythmia DUE TO (OR AS A CONSEQUENCE OF):										
	IMMEDIATE CAUSE (Final disease or condition	DUE TO (OR A	S A CONSE	OUENCE OF):	anter tha m	ode of dying, suc	ch ss c	cardiac or respir	retory stre	Approximate Interval Between Onset and Daath	
SERTIFICATION	IMMEDIATE CAUSE (Final disease or condition	let only one cause on	S A CONSE	OUENCE OF):	anter tha m	ode of dying, suc	ch ss c	ardiac or respir	retory street	Approximate Interval Between Onset and Daath	
MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significent conditions	DUE TO (OR ALL OUTE TO (OR ALL	S A CONSE	OUENCE OF): OUENCE OF): resulting in 1	h mia	ode of dying, suc	Part I	. 24s. WAS AN A PERFORE 1 YES 2	AUTOPSY MED?	st, Approximate Interval Between	
MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR ALL OUTE TO (OR ALL	S A CONSE	OUENCE OF): OUENCE OF): Treeulting in t	h mia	ng cause given in	Part I	. 24s. WAS AN A PERFORE 1 YES 2	AUTOPSY MED?	Approximate interval Between Onset and Daath HOURS HOURS LANGE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
5 -	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS OUT TO (OR AS OU	S A CONSE	OUENCE OF): OUENCE OF): OUENCE OF): Televiting in 1	h mia	ng cause given in	Part I.	. 24a. WAS AN A PERFORI	AUTOPSY MED?	Approximate interval Between Onset and Daath HOURS HOURS LANGE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR ALL DUE TO	S A CONSE	OUENCE OF): OUENCE OF): OUENCE OF): TOUGHT YES CE OF DEATH (OUENCE OF): OUENCE OF):	the underlylr NO [Check only one, THER: Nursing Hor	DODGE OF CONTROL OF CO	Part I	. 24s. WAS AN A PERFORI 1 YES 2	AUTOPSY MED?	Approximate interval Between Onset and Daath HOURS HOURS 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending	DUE TO (OR AS OUT TO (OR AS OU	S A CONSE	OUENCE OF): OUENCE OF): OUENCE OF): TOUENCE OF): TOUENCE OF):	the underlylr NO E Check only one THER: Nursing Hor	ng cause given in	Part I	. 24a. WAS AN A PERFORI	AUTOPSY MED?	Approximate interval Between Onset and Daath HOURS HOURS 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL	Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 22 NO 27. MANNER OF OEATH 1 Netural 5 Pending	DUE TO (OR ALL DUE TO	S A CONSE	GUENCE OF): OUENCE OF): OUENCE OF): Tresulting in 1 ATH YES DE OF DEATH (DOA 4 28b. TIME OF INJURY)	the underlying NO E Check only one THER: Nursing Hor W M 1	DUNCERTAIL UNCERTAIL	Part I.	. 24s. WAS AN / PERFORI 1 YES 2	AUTOPSY MED?	Approximate interval Between Onset and Daath HOURS HOURS 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
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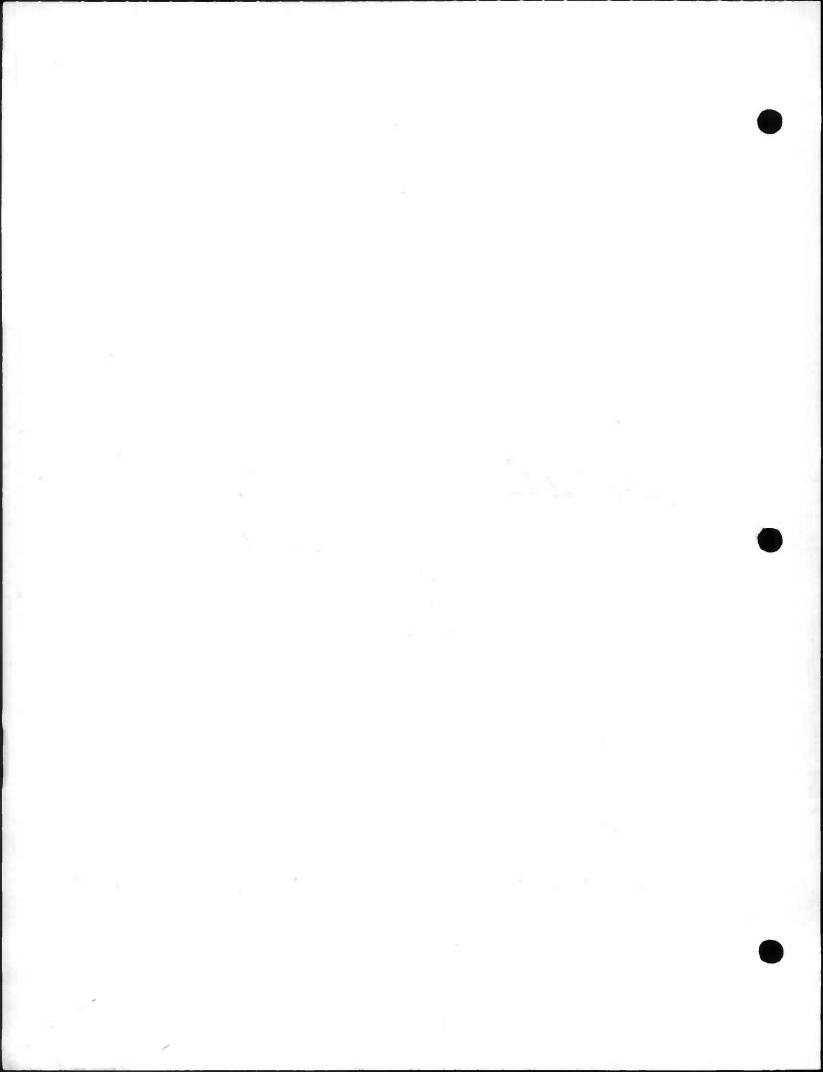


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within F hours after death. Page 6 may be retained by the hospital or attending physician	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, or Health and Mental Hygiene prior to burial, cremation, or removal.	
IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF MA					EALTH AND	MEI	NTAL HYGIEN REG. NO.			
j.	1. DECEDENT'S NAME (First, Middle, Last)	**						2.	DATE OF DEATH			3. TIME OF DEATH
	Ja	mes Henry	Love,	Sr.					March 7,	1995	YEAR	7:43 AM
18	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. I	ast birthday)	IF UNDER		IF UNDER 24 HRS	7.	DATE OF BIRTH			IPLACE (State or Foreign
ı	215-14-5355	1 M 2 - F	72	YRS.	MONTHS	DAYS	HOURS MIN.		0/27/192	22		rvland
-	9e. FACILITY NAME (If not institution, give at				1	CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
DIRECTOR	Johns Hopkins Ba	ayview Med	dical (ctr.		Balt	imore (City	7			N/A
EC	10e. STATE 10b. COUNTY	,		10c, CIT	Y, TOWN (OR LOCAT	ION					10d. INSIDE CITY
H	Maryland Bal	timore					Dunda	alk				LIMITS?
	10e. STREET AND NUMBER					101	ZIP CODE			10g. CITI	ZEN OF V	WHAT COUNTRY?
FUNERAL	215 Trappe Road						212	22		Un	ited	States
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. A	AMED					RIGIN? (Specify Yes	or No-	14. RACE	E — American Indien,
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES				2 NO Spe		erro Hicen, etc.)			"y: White
	15. DECEDENT'S EDUC	CATION	100.0	WW I	-	201104710		-				WITTLE
H	(Specify only highest grade	completed)	1 (Give kind of the Do NOT u	work done	during mo	st of working		16b. KIND OF BUS	SINESS/IND	USTRY	
7	Elementary/Secondary (0-12) 8 Years	College (1-4 or S+)		echan					Elect	ric C	oro.	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S	NAME (First, Middle, Maiden			
BE C	James Henry Love	е							mith Web	,		
10 8	19e. INFORMANT'S NAME (Type/Print)		1						Number, City or Town		Code)	
F	Mary J. Whithorn	<u> </u>		239 '	Irapp	e R	oad Du	nda	lk, Mary	land	212	222
Ĩ	20e, METHOD OF DISPOSITION 1 ABurlel 2 Cremation 3 Remo	oval from State	20b. PLACE	AND DATE	OF DISPOS	ITION (Na	me ol		DATE 20c. LO			
	4 Donation 8 Other (Specify)		Cak	Lawn						ltimo		
	2 Al				22.	Dud	ADDRESS OF ADDRESS OF	Fun	eral Hom	e of	Dung	dalk, Inc.
	31 (M	<u></u>				792	2 Wise	Ave	 Dunda. 	lk, M	D 2	21222
1	23. PART I. Enter the diseases, or c ahock, or heart failure. I	omplications that List only one cause	caused the d	leath. Do i	not enter	the mo	de of dying, s	uch as	cardiac or respi	ratory arre	est,	Approximate Interval Between
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final										Onset and Death	
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J			orde	opu	lui	ou	arre	st				
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NOI	resulting in desth) Sequentially list conditions,	b	PR AS A CONSI		lui HF	- (arre	st	-			
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TO THE MOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be assented withher hours after death. Page 6 may be retained by the stranding physician.

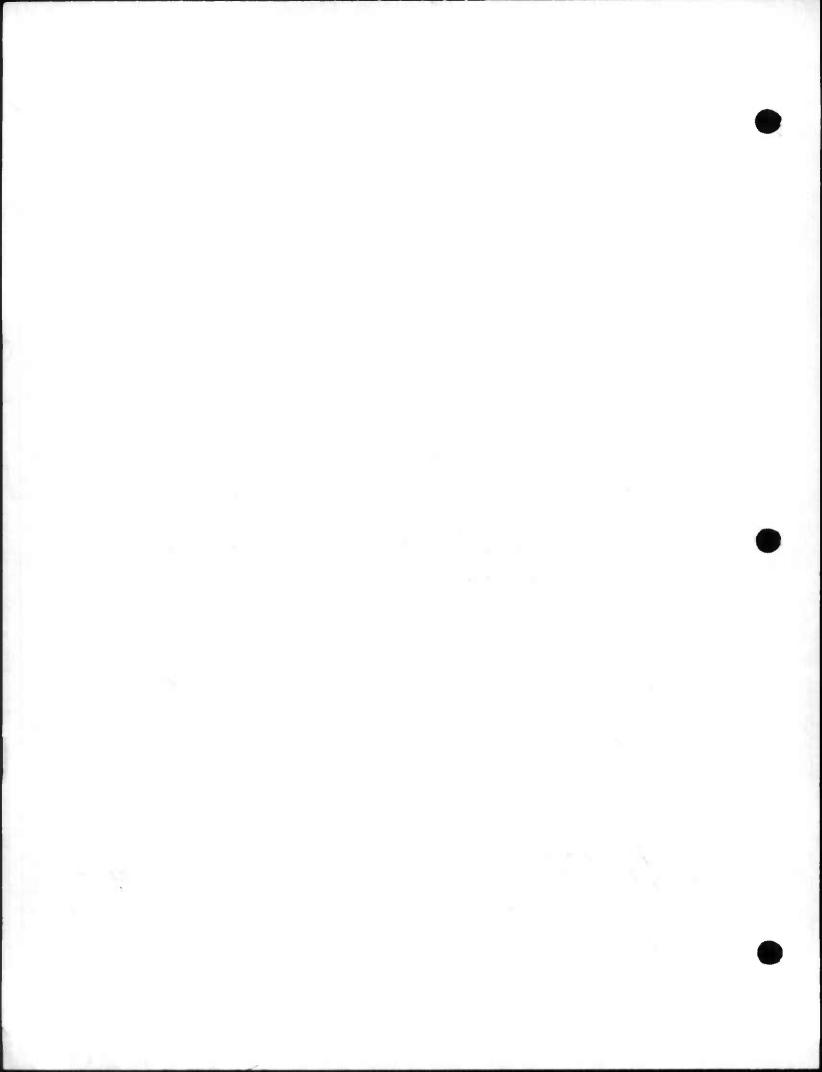
TO THE FUNETAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mestal Hygens prior to furth, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	- HEGISTRAR		CERT	FICALE (OF DEATH	REG. NO.							
	1. OECEDENT'S NAME (First, Middle, Last)				**	2. DATE OF DEATH		3	. TIME OF OEATH				
	LER()Y LIDE	7				MONTH D		YEAR					
- 1		1				3 4	199	15	12:10 P.M				
1	4, SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. last birthda			7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPL	ACE (State or Foreign				
İ	219-32-8728	1 TyM 2 🗆 F	8 YRS	MONTHS DA	YS HOURS MIN.	1/5/1932		Country)	TMODE IM				
	9a. FACILITY NAME (If not institution, give		70	Ob CITY TO	WN OR LOCATION OF DE				IMORE, MD				
l œ		,		96. СП 1, 10	WH OR LOCATION OF DE	ATH	9c. COUNT	TY OF OEAT	TH				
١ō	1618 MORELAND AV	VE.		BALTI	MORE		CIT	Y					
5	RESIDENCE OF DECEDENT						011						
DIRECTOR	10a. STATE 10b. COUNT	TY .	10c. (HTY, TOWN OR L	DCATION			10	Dd. INSIDE CITY				
5	MARYLAND S	The Cit	(B	ALTIMOR	T.				LIMITS?				
ب	10e. STREET AND NUMBER	11.0.	7	ALTIMON	10f. ZIP COOE				4.4				
\$			/		101. 21P CODE		10g. CITIZI	EN OF WHA	AT COUNTRY?				
FUNERAL	1618 MORELAND AV	/E.			21216		USA						
5	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS	DECENDENT OF HISPAN	IC ORIGIN? (Specify Yes	or No —	14. RACE -	- American Indien, Vhite, etc.				
	1 Never Married 2 Merried	FORCES? 1 7	ES 2 KINO	If ye	s, specify Cuben, Mexical YES 2 X NO Specify	n, Puerto Rican, etc.)			Vhite, etc.				
₩	3 Widowed 4 Divorced		I DAILO	1 ''	TES 2 KI NO Specify			AFR.	AMERICAN				
	15. OECEDENT'S EOU	ICATION	Mr. DECEDENC	'S USUAL OCCU					MILITOAN				
ETE	(Specify only highest grade	completed)	(Give kind)	of work done durin	g most of working	16b. KIND OF BUS	SINESS/INDU	STRY					
"	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)		use retired.)									
_ €	12		MACHI	NIST		INDENPEN	NDENT	CAN	CO.				
once.	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Meiden	Sumamal						
70	DAVID LIDE				ANNIE	K. LII							
ed a	19a. INFORMANT'S NAME (Type/Print)						_						
TO BE					eet end Number or Rural F								
90	ADRIENNE ROXANN	8	1618	MORELA	ND AVE, BA	LTIMORE, N	IARYLA	AND 2	1216				
=	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Ren		20b. PLACE AND DAT	E OF DISPOSITIO	N (Name of	DATE 20c. LO	CATION — CI	ty or Town,	State				
must	4 Donation 5 Other (Specify)	noval from State	ARBITUS	r other place) MFMΩRTΔ	L PK. 3/9/	Q5 ADD	מוחווכ	MADS	ZT A NTD				
6	21. SIGNATURE, OF FUNERAL SERVICE IN	CENSEE ()	//				UTUS,	PIAR	LLAND				
examiner	22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME.P.A.												
8	Hurry	1300 EUTAW PLACE, BALTIMORE, MD. 21217											
8	23. PART I. Fotor the diseases or	complications that care	and the death D	1130	O EUIAW PL	ACE, DALII	MUKE,	MD.					
medical	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate interval Between												
	IMMEDIATE CAUSE (Final	,	-	-	,				Onset and Death				
th.	disease or condition	Alson "	mall	(41)	Link	(MAKE	0						
event,	resoluting in dealth)	DUE TO (OR A	B A CONSEQUENCE	OF	00,09	CONCE	~						
		Panica	2014	1 64	6000	-			i				
traumatic	disease or condition and the state of the st												
B E	if any, leading to immediate cause. Enter UNDERLYING	DOE TO TON A	a v countranciarie	OFF II									
취실	CAUSE (Disease or Injury	£											
other TIF	that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
y, or other traumatic CERTIFICATION	resulting in death) LAST												
¥ 0	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FRIDINGS												
Injury.	PART II. Other significant condition	ns contributing to death	but not resulting	in the under	ying cause given in i	Part I. 24s. WAS AN			ERE AUTOPSY FINDINGS				
EDICAL						PERFOR			RILABLE PRIOR TO DMPLETION OF CAUSE				
E 0						t VES 2	N HO		DEATHY				
apon W								1.1	☐ YES 2 ☐ NO				
23 A	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	ES NO	☐ UNCERTAIN								
E X	25. WAS CASE REFERRED TO MEDICAL		26, PLACE OF DE	ATH /Check only	orter)			_					
ed, or item 23 s PHYSICIAN:	1 YES 2 NO	HOSPITAL:	utual a Class	OTHER:	/	12000 E Sec							
5 ×	27. MANNER OF DEATH	-		The same of the same of	Home 5 Residence	The state of the s							
marked, BY PH	1 Natural 5 Pending	(Month, Day, The		ME OF 28c	INJURY AT WORK?	384. DESCRIBE HOW IN	NUM OCCU	HED					
By By	2 Accident Investigation			м ,	YES 2 NO								
	3 Suittide & Could not be	28s. PLACE OF HUJU building, etc. (S	RY - At home, farm	street, factory,	office	201. LOCATION (Street at	nd Number or	Hursi Routi	a Number				
99 W	4 Homicide determined	monardy, etc. (3)	pecify			City or Town, States							
E E	28s. CERTIFIER FORESTER BANK												
흴릴	parties and Contra the and Pierra	ICIAN: To the best of my kn							2/				
COMP	2 MEDICAL EXAMINE	IR: On the besis of exemina	tion and/or investige	tion, in my opinio	n, death occured at the t	time, date and place, and	d due to the	Cause of M	Tonner as stated.				
\$ O	286, SIGNATURE AND POLE OF CERTIFIE	p			_			- 14	1				
MPORTANT: If Item O BE COMPLE	Miller	hAD.			196, LICENSE NUM	BEH	29d. DATE S	HIGHER	tirety Day, Vear)				
7 0	- sunner	IVU .			1 516	30	1 3	-08-	75				
115	NAME AND ADDRESS OF PERSON-WH	O COMPLETED CAUSE OF	DEATH (ITEM 27) (Ty	oe, P(nt)				2	-				
	22 5. GT	UURNE	51.	DAU	Mone	. MD.	. (117	01				
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI		-	1	,							
	444	14. 4											
	MAR 1 4 1995	Julia Davidson	Mardall										



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital on the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cernation, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARY	AND / DEPARTM CERTIFIC	MENT OF H	EALTH AND M	ENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)	- 1				2. DATE OF DEATH		3. TIME OF DEATH			
	Albert F	King L	ambert		- 1	March		95 0013 m			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8,1	BIRTHPLACE (State or Foreign Country)			
	213-30-3699	1 🔀 M 2 🗌 F	70 YRS. MO	NTHS DAYS	HOURS MIN.	03-21-1					
	9a. FACILITY NAME (If not institution, give stre				CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
OR	Union Memorial	. Hospital		Balt	lmore Ci	ty	Ci	ty			
딩	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY		400 CITY T	OWN OR LOCAT	1011		10d. INSIDE CITY				
DIRECTOR		ity					LIMITS?				
	10e, STREET AND NUMBER	<u> 1 t y </u>	Bal	timor	ZIP CODE	100 CITIZEN	1 √ YES 2 □ NO				
FUNERAL	2609 Brendan	λπο		1	21213)					
Š		IN U.S. ARMED	13, WAS DEC		ORIGIN? (Specify Yea	US.	RACE — American Indian.				
	1 Never Merried 2 🔀 Married	FORCES? 1 X YES		If yes, spe	cify Cuben, Maxican, 2 NO Specify:	Puerto Rican, etc.)		Black, White, etc. Specify:			
BY	3 Widowed 4 Divorced		VII		a green,		1	White			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. DECEDENT'S USI	done during mo:	N at of working	16b. KIND OF BUS	SINESS/INDUST	TRY			
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)							
MP	12	0	Boile	rmake	r	Heavy	Cons	truction			
8	17. FATHER'S NAME (First, Middle, Lest) Albert K.	Tambas	. 1.			(First, Middle, Maiden					
BE	The state of the s	Lamber			Kanna		Suthe.				
2	190. INFORMANT'S NAME (Type/Print) Regina Lamber	rt				ate Number, City or Tow					
	20a. METHOD OF DISPOSITION					Balto. M					
	1 N Buriel 2 Cremetion 3 Remov	vai from State co	b. PLACE AND DATE OF D metery, crematory or other	nlecel				or Town, State			
	21. SIGNATURE OF JUNERAL SERVICE LICE	NSEE 1	ioly Rosa	ry Cel	Cemetery 03/15 Baltimore, Md. ME AND ADDRESS OF FACILITY						
	della.	1.101.				er Fune	ral H	ome			
_	Typen (len)	Wood		401	01 S. Chester St. Balto. Md. 21231						
	23. PART F. Enter the diseesee, or co ehock, or heert fellure. Li	emplications that cause let only one cause on a	d the deeth. Do not sech line.	enter the mo	de of dying, such	ns cerdlec or reepl	ratory errest	Approximate interval Between			
	IMMEDIATE CAUSE (Finsi disease or condition							Onset and Death			
ļ	resulting in death)	Arrh	y tumica	-				2310 (2 hrs			
	disease or condition — Arrhy thmaa — 2310°(Due to (or as a consequence of):										
O	Sequentisity list conditions, If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury) CAUSE (Disease or injury) 2200(3)										
AT	If any, leading to immediate cause. Enter UNDERLYING	Dun	man	2 der	no_			2200 (3 hi			
F	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):					~~~~			
PHYSICIAN: MEDICAL CERTIFICATION	reculting in death) LAST										
Ö	PART II. Other eignificent conditions	contribution to doubt									
NA.	Aspiration	contributing to deeth	Util ein	ne underlying	csuse given in Ps	ort i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
ă	Aspirocitor	1, 2500	0,0327			_ 1 TYES 2	NO	COMPLETION OF CAUSE OF DEATH?			
Σ	DID TODA CCO LIST COLUTIN					_		1 YES 2 NO			
AN	DID TOBACCO USE CONTRI	BUTE TO CAUSE C			UNCERTAIN						
2	EXAMINER?	HOSPITAL:		THER:							
¥ l	1 YES 2 NO	1 Inpatient 2 ER/Out 28s. DATE OF INJURY	patient 3 DOA 4 (5 Residence 8						
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WOI		8d. DEŞCRIBE HOW II	AJORA OCCUR	ED			
B	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE OF INJUR	Y — At home, farm, atree			Bt LOCATION (Street o	and Number or G	Purel Courte Alumbar			
	4 Homicide 6 Could not be	building, atc. (Spe	cify)	i, incidity, diffice	1	City or Town, State)	et and Number or Rural Route Number, te)				
91	29a. CERTIFIER		MILET PORTS				-				
COMPLETED		AN: To the best of my know						suse(s) and manner as stated.			
8		On the Date of Statistics	and/or investigation, in	i my opinion, or			d dua to the ca	use(s) and manner as stated.			
BE	296, SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBI						
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (\$4.5 CT	et)	AUB27	07	TILA	RCH 12, 1995			
	KATHLEEN B	URGESS	29 Scur	y PAC	BALT	imore	m13 2	1241			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN			11112						
- 6	MAND & A LOOS /1.	0 0									

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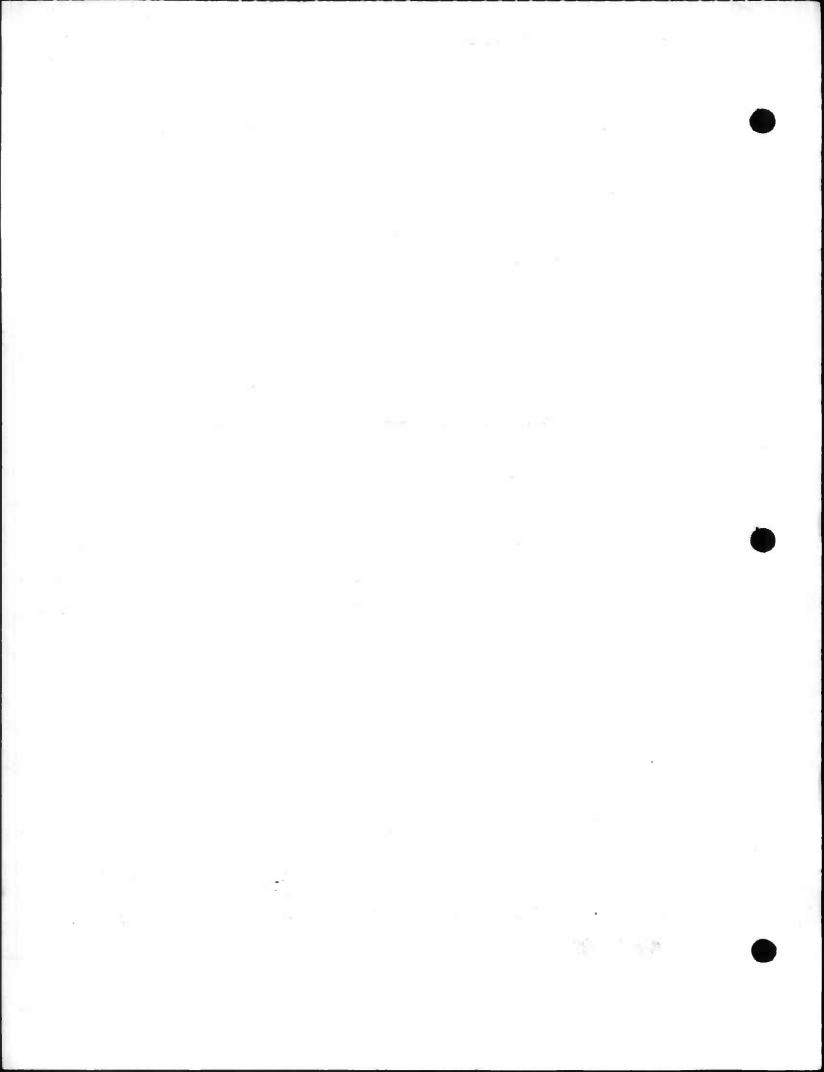
Jeli Devilen Rachel

estate - 2. Det

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the fours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notiffed at once.

	1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Lest) DELOR	ES Ellen N	1ARSh	pLL		2. DATE OF DEATH	DAY Y	S. TIME OF DEATH A			
	4. SOCIAL SECURITY NUMBER 220-64-2839		In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MOTICE 31,	1	BIRTHPLACE (State or Foreign Country) Maryland			
OR	9a. FACILITY NAME (If not institution, give si Maryland General			96. CITY, TOWN O	OR LOCATION OF E	DEATH	9c. COUNTY	OF DEATH			
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland N/A	1		r, town on Loca ltimore	TION			10d. INSIDE CITY LIMITS?			
FUNERAL	100. STREET AND NUMBER 4361 Shamrock Av	enue		10:	21206		U.S.	1 X YES 2 NO N OF WHAT COUNTRY?			
ВҰ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	NU.S. ARMED 2 ANO ATES	If yea, sp	ENDENT OF HISPA ecity Cuban, Maxic 2 X NO Speci	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	1	RACE — American Indian, Black, Whita, atc. Specify: White			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elamentary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT u Secret	USUAL OCCUPATION work done during mose retired.)	ON st of working	16b. KIND OF BU					
NO	17. FATHER'S NAME (First, Middle, Last)		00000		18. MOTHER'S N.	AME (First, Middle, Malden		pr./sune			
BE (Leroy Edwin Breni	neman Sr.				es Ellen Mo					
5	19a. INFORMANT'S NAME (Type/Print) Delores E. Brenne	eman (Mather	196 MAILING	ADDRESS (Street &	oh Association	Route Number, City or Tow IE, Baltimo	vn. State, Zip Co	de)			
	20e, METHOD OF DISPOSITION 1 Surial 2 Cremetton 3 Rame	206	.PLACE AND DATE	OF DISPOSITION /NA	me of	DATE 20c 10	CATION CITY	or Town State			
	4 Donation 5 Other (Specify)	Mc	St Holy	Redeeme	r Cem. 3	/14/95 Ba	ltimor	e, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LIC	Costo		Schii 3331	munek Fu Brehms	ineral Home Lane. Bal	timore	. Md. 21213			
		complications that caused List only one cause on a	the deeth. Do	not enter the mo	de of dyling, suc	ch es cerdlec or reep	Iratory srrest	Interval Between			
	IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	Preym	CONSEQUENCE O	tis Co	annii l	neumon	ia_	Onsat and Dasth			
ATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): ACUTE Respiratory Squire Minutes 1002										
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	QUE TO (OR AS A	CONSEQUENCE O	F):	16/61	icy synd	ALOM!	1173			
MEDICAL	PART II. Other eignificent condition	e contributing to deeth b	ut not resulting	In the underlying	g ceuse given in	Pert I. 24n. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?			
	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YI	S \square NO \square	UNCERTAI	<u>п</u> П		1 TYES 2 TO NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA								
HYSI	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	atlent 3 DOA	4 - Nursing Hom		6 Other (Specify) 28d. DESCRIBE HOW	IN III IBY OCCUB	F0			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		IURY WO	RK? ZES 2 NO	and Describe NOW	NOON OCCOR	EU			
8	3 Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE OF INJURY building, atc. (Spec	— At homa, farm,	street, factory, office		281. LOCATION (Street City or Town, State)		Bural Route Number,			
COMPLET		CIAN: To the best of my knowl R: On the basis of examination						Buse(a) and manner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	D. quetto			29c. LICENSE NU	MBER	29d. DATE SI	GNED (Month, Day, Year)			
10	30. NAME AND ADDRESS OF PERSON WHO	Karan M.	D. C		yland	GENERAL	Has	pital			
	31. DATE FILED (Month, Day, Year) MAR 1 4 1995	32. REGISTRAR'S SIGN	AŢURE								



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the bage 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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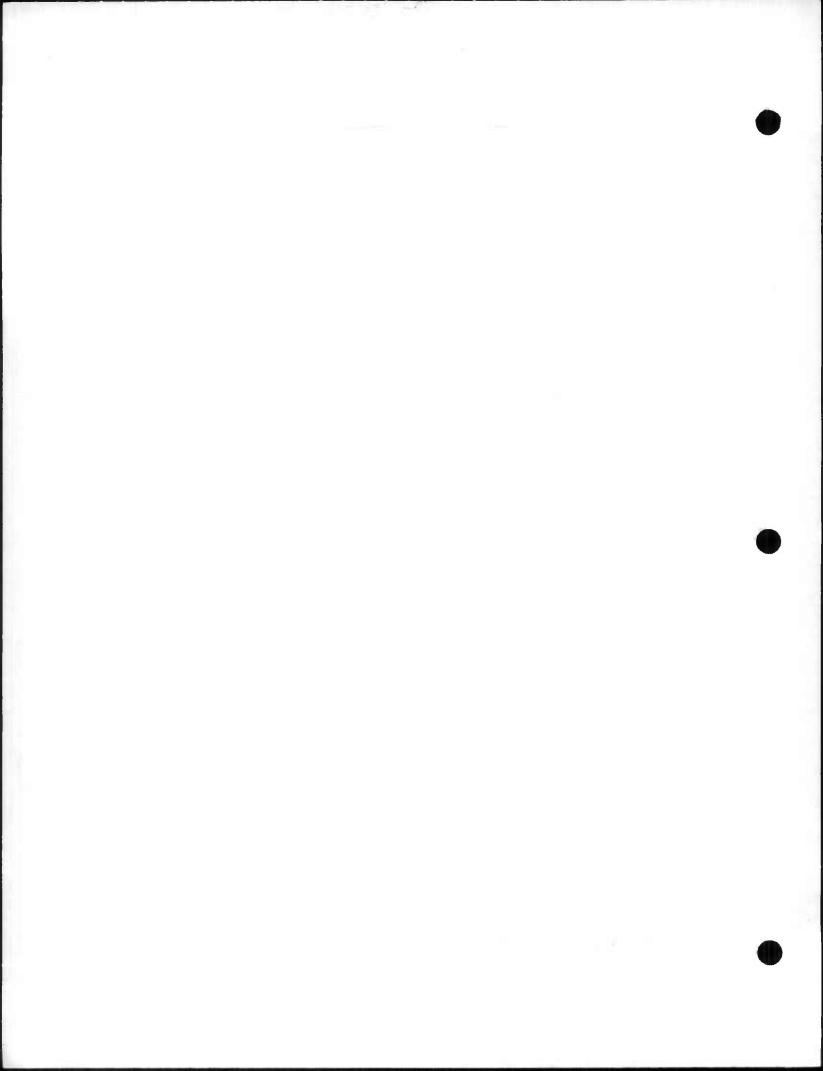
1 4 1995

	Item1 3-14-95 Fi	1mG/21	W.H.Pe	r F/H							95) (7647
	1 - STATE REGISTRAR	STATE OF M		/ DEPAR						YGIENI EG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) JOHN Francis	Josep	h	-M	EVEDO	MY	ERS		2. DATE OF D MONTH MARCH	DEATH DA	1	995"	3. TIME OF DEATH 10:04 A M
	4. SOCIAL SECURITY NUMBER 5.		8. AGE (In yrs. Ia		IF UNDER	_	IF UNDER 2	MIN.	7. DATE OF B	NALH		8. BIRTH	IPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street	end number)			9b. CITY,	TOWN C	OR LOCATIO	N OF DE		+, I.		NTY OF D	-
O. H	JOHNS HOPKINS HOSP	ITAL			BAI	TIM	ORE				N/A		
급	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c CIT	Y, TOWN C	R L OCAT	TON						
DIRECTOR	Maryland N/A				1tim		ION						10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	10e. STREET AND NUMBER						. ZIP CODE				10g. CIT	ZEN OF V	VHAT COUNTRY?
FUNERAL	2800 Bayonne Avenue	2					21214	'			U.	S.A.	
1 2	11. MARITAL STATUS 1 ☐ Never Merried 2 ☒ Merried 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO					MAS DEC	ENDENT OF	HISPAN	IC ORIGIN? (Sp	ecify Yes	or No-	14. RACE	— American Indian, t, White, etc.
₽	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1	_ YES	2 X) NO	Specify		, 4.0.,		Speci	
0	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	ON State of	16a. D	ECEDENT'S	USUAL OC	CUPATIO	ON		16b. KINI	D OF BUS	INESS/IND	DUSTRY	WIIICC
	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+))	Give kind of vie. Do NOT us		furing mo:	si of working						
COMPLETED	12th 17. FATHER'S NAME (First, Middle, Last)		S	alesm	an				_		Com	pany	
	Charles John Myers								NE (First, Middle Virgi		-	nus	
BE	19e. INFORMANT'S NAME (Type/Print)		11	9b. MAILING	ADDRESS	(Street a			oute Number, C				
2	Jean Frances Myers	(Wife)		2800					Balti				1214
	20e METHOD OF DISPOSITION 1 & Burlet 2 Cremetion 3 Removal from State 4 Donotion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery Cremetory or other place) Parkwood Cemetery 3/16/95 Baltimore												
	4 Donetion 5 Other (Specify)	re .	Parkw	ood (ID ADDRESS		/16/95	Ва	ltim	ore,	Maryland
	Robert Arford	ack)		S	chim 331	unek Brehn	Fun ns L	eral H ane, B	alti	more	, Md	. 21213
	23. PART I. Enter the diseases, or comp shock, or heart failure. List	plications that only one caus	cau ed tha d	leath. Do r	not anter	tha mo	da of dyln	g, such	as cardiac	or raspir	atory sn	rest,	Approximats interval Batween
	iMMEDIATE CAUSE (Fine) disease or condition	CINIC	Char 1	N-2711	CIAI	Pr-	Her	20					Onset and Death
	resulting in death) a.	DUE TO (OR AS A CONSE	OUENCE OF		91	HOI	47					
Z	Sequentially list conditions, b												
ATIC	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	OUENCE OF	F):								
SFI	CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF	j:								
ERTIFICATION	resulting in death) LAST												
LC	PART ii. Other significent conditions co	entributing to d	death but not	resulting i	in the un	deriying	ceuse gi	ven in F	Part i. 24s.	WAS AN A	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL							99		100	PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME									_ >				OF DEATH? 1 YES 2 □ NO
ä	DID TOBACCO USE CONTRIBU	JTE TO CAL					UNCE	RTAIN					,
PHYSICIAN:		SPITAL:		CE OF DEAT	H (Check o								
HYS	27. MANNER OF DEATH	Inpatient 2 28e. DATE OF II		3 DOA	7	ing Home		Idence (Other (Spe 28d. DESCRIB		HIBW OC	NIBED	
ВУ Р	1 Netural 5 Pending	3/12		032	URY	WOI	RK?	NO	SUBT	20	944	T	
	3 Suicide 8 Could not be	28e. PLACE OF building, e	INJURY — At he	ome, farm, s		ory, office	1		281. LOCATION City or Tox	(Street er	nd Number	or Rural F	Noute Number, AND
COMPLETED	4 Homicide determined		BAR						4315	HAR	FORD	RD.	BALTIMORES
MPL	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN:												Minimum and an arrange
	2 MEDICAL EXAMINER: On 290 SIGNATURE AND TITLA OF CERTIFYER	~	A Property of the Property of	irrvestigatio	n, in my o	oinion, de				place, and			
H		11-1	7				29c. LICEN	SE NUMI				E SIGNEO LARCH	(Morith, Day, Year) 1 13,1995

PENN STREET, BALTIMORE, MARYLAND 21201

HO COMPLETED CALLE OF DEATH (ITEM 27) (Type, Print)

P. REGISTRAR'S SIGNATURE



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Wilma G. Mikulic 1995 10. 4:40 P. March 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) Oct. 4, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 220-14-7258 1 M 2 X F 85 YRS. 1909 Illinois permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4121 Baker Lane Baltimore Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 19c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4121 Baker Lane funeral director, page 5 should be detached for use as the burial-transit 21236 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 ANO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 X Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only I Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th grade Baker's Helper Bakery 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 7 Kalisch Martin Rehde Catherine BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Norma Zerhusen (sister) 4121 Baker Lane, Baltimore, MD 21236 within 24 hours after death. Page 6 may be e e 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Moreland Memorial Park 3/14 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. Rell. 9705 Belair Rd., Baltimore, MD 21236 in and completely filled in by the to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate ahock, or heert failure. List only one cause on each line. Interval Retur IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition ardiac event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed SLUB traumatic CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leeding to immediate attending physician ntal Hygiene prior to cause. Enter UNDERLYING Leria CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initieted eventa reaulting in death) LAST 0 signed by the atte PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? апу 1 TYES 2 THO 1 YES 2 740 t, of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO-MEDICAL 26. PLACE OF OEATH (Check only one) certificate to the State HOSPITAL: 1 YES 2 NO 1 🗆 Inpatient 2 🗀 ER/Outpetient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED this with marked, 1 Natural 5 Pending 1 YES 2 NO BY After Investigation 2 Accident ATTENOING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED OIRECTOR: / 6 Could not be 4 Homicide 28 detarmined OR 29a. CERTIFIER ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL within 72 * TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II mination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE 29c_LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year, Tendu -16444 March-13-1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. V. S. Nair, 2112 Belair Rd., Suite 5, Fallston, MD 21047 32. PEGISTRAR'S SIGNATURE

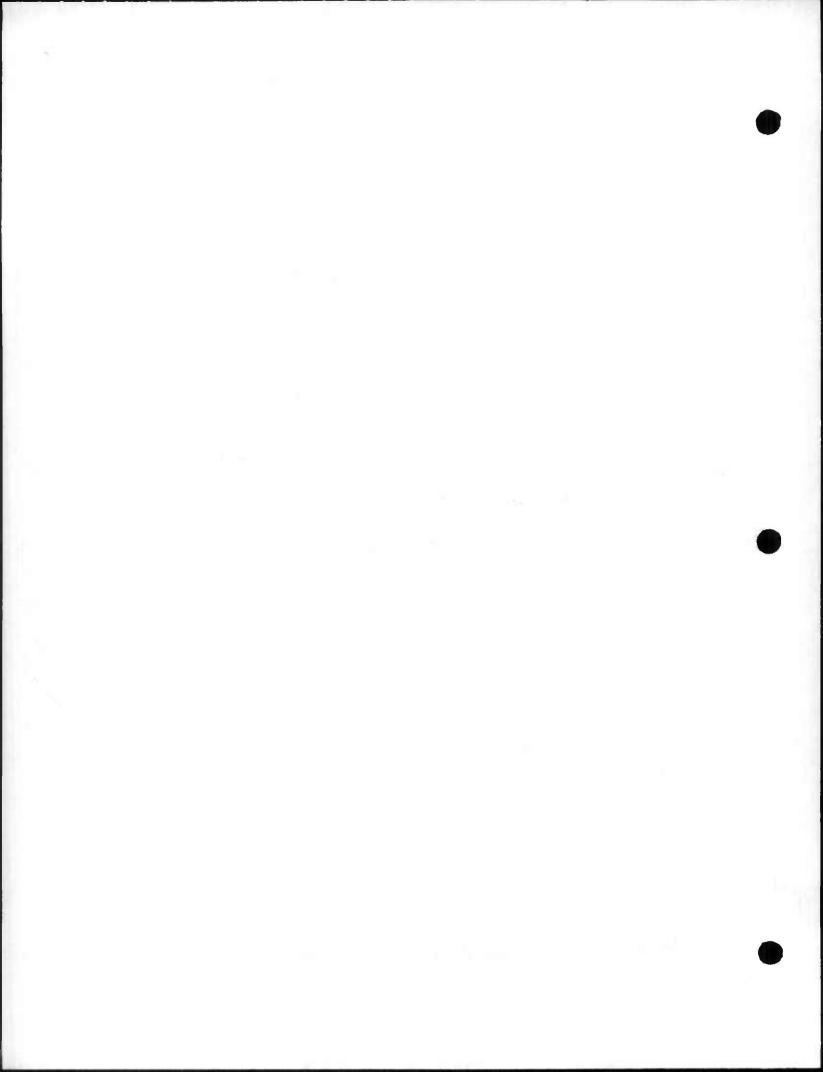
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examples must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) Andrew P. Murphy,			2. DATE OF DEATH MONTH MONTH 6,		3. TIME OF DEATN 08:55 A. M				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. 032-24-8542 1 X M 2 ☐ F 72	-	F UNDER 1 YEAR IF UNDER 24 HF ONTHS DAYS HOURS MH	S. 7. DATE OF BIRTH	8. BIR	THPLACE (State or Foreign				
TOR	99. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL RESIDENCE OF DECEDENT	9	GLEN BURNIE	F DEATH	9c. COUNTY OF DEATH A.A. COUNTY					
DIRECTOR	MARYLAND ANNE ARUNDEL	10c. CITY, 1	OWN OR LOCATION GIBSON ISLAN	D	10d. INSIDE CITY LIMITS? 1 YES 2 1 NO					
FUNERAL	100. STREET AND NUMBER SKYWATER ROAD		10f. ZIP CODE 21056			WHAT COUNTRY?				
BY FUI	11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. WAS DECEDENT_EVER IN U.S. FORCES? 1 1 ☐ YES 2 ☐ IF YES, GIVE WAR OR DATES	ARMED NO	13. WAS DECENDENT OF NIS If yes, specify Cuben, Me 1 YES 2 NO Sc	xican, Puerto Rican, etc.)	Ble	CE — American Indian, ick, White, etc.				
COMPLETED	(Specify only highest grade completed)	DECEDENT'S US (Give kind of work life. Do NOT use n ATTORN		PATION 16b. KIND OF BUSINESS/INDUSTRY LEGAL						
BE COI	17. FATHER'S NAME (First, Middle, Last) ANDREW P. MURPHY, SR.		IREN	NAME (First, Middle, Maide E MARIE O C	ONNELL					
10	ANN MARIE MURPHY	SKYWAT	DRESS (Street and Number or Rt ER ROAD, GIBS	ON ISLAND,	wn, State, Zip Code) MARYLAND	21056				
	1 □ Buriel 2 ☑A-Cremation 3 □ Removal from State cometery,	cremetory or other	DISPOSITION (Name of place) ASHINGTON CRE 22. NAME AND ADDRESS OF	M 3/7 LA	UREL, MA	RYLAND				
	7601 SANDY SPRING ROAD, LAUREL, MD 20707									
	23. PART I Enter the disease, or complications that owned the shock, or heart failure. List only one cause of each in IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ne.			piratory street,	Approximate interval Between Onset and Desth				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Carcinoma a cophagus 10months									
AL	PART II. Other significant conditions contributing to death but not	t resulting in t	he underlying ceuse given	PERFO	RMED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE				
N: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YES	□ NO □ UNCERT.	AIN ID	2 (1)40	OF DEATH?				
PHYSICIAN:		ACE OF OEATN (
ву рну	27. MANNER OF DEATN 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	286. TIME O	F 28c. INJURY AT	28d. DESCRIBE NOW	INJURY OCCURED					
	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At building, stc. (Specify)	home, ferm, atre	ot, tectory, affice	28f, LOCATION (Street City or Town, State	and Number or Rural)	Route Number,				
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: On the best of examination and/or	death occurred a	t the time, date and place, and a my opinion, death occured st	due to the cause(a) and me the time, data and place, e	nner se stated.	(a) and menner as stated.				
TO BE C	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (IT	1	4D 29c. LICENSE D449	-	29d. DATE SIGNE	D (Month, Day, Year) 47, 1995				
	Gurmeet Sawhney M.D. 325 Hospit 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	al Driv	ve #202 Glen	Burnie, Mar	yland 210	061				
	MAR 1 4 1995 Juli Maria Rev 1/89									



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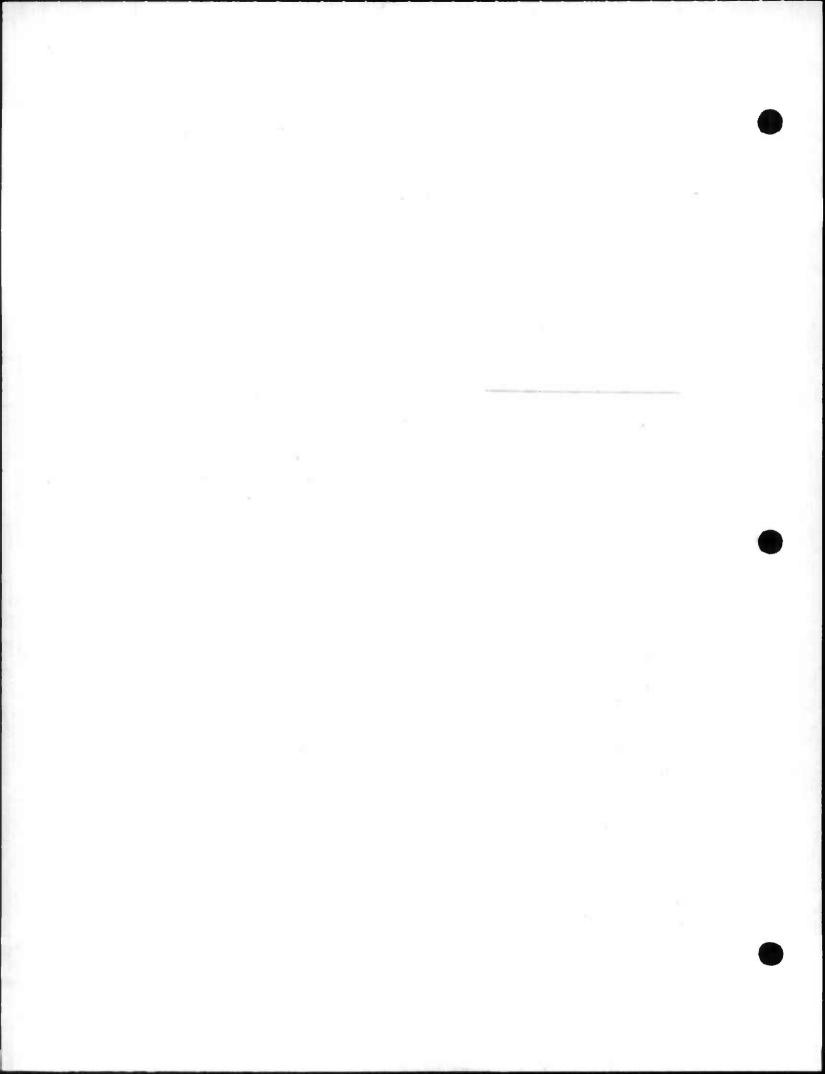
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	To first our suctions, when with definition to your examinating protection are not continued in order of the burial-transit permit. Pages 1, 2, 3 s. the transmission of the permit of t	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL	filed within 72 h	PORTANT: If I

	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)	Rita Pat	ricia Ma	ıtheu			AY YEAR			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	March 10 7. DATE OF BIRTH (Month, Dwy, Year) Sept. 18	0.00	11:00 PM M		
	211 21 0100	1□M2¤F 66	YRS.	MONTHS DAYS	HOURS MIN.	aryland				
Œ	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	F DEATH					
010	308 Crisfield Cou	urt		ADII	ngdon		Harfo	ora		
DIRECTOR	Maryland 106. COUNTY	Harford	10c. CIT	Y, TOWN OR LOCAT		ngdon	10d. INSIDE CITY LIMITS? 1 YES IVENO			
RAL	10e. STREET AND NUMBER	1		101	. ZIP CODE	1000		F WHAT COUNTRY?		
FUNERAL	308 Crisfield Cou	ITC 12. WAS DECEDENT EVER IN	I U.S. ARMED	13. WAS DEC		IC ORIGIN? (Specify Yes		States ACE - American Indian.		
ВУ	1 ☐ Nover Married 2∑Married 3 ☐ Widowed 4 ☐ Divorced	FORCES? 1 YES	2 XNO	It yes, sp		n, Puerto Rican, etc.)	BI	eck, white, arc.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	TION Impleted) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of v life. Do NOT us	USUAL OCCUPATION Work done during more retired.)	ON st of working	16b. KIND OF BUS	SINESS/INDUSTRY	,		
11 Years Office Manager Seafood Corp.							d Corp.			
BE	John Bish, Sr. 19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Bural I	Anna Mat				
5	Mr. Michael Mathe	eu				Abingdon		and 21009		
	20a, METHOD OF DISPOSITION 1 & Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from Stata 20b.	PLACE AND DATE Of	of Disposition (Na ther place).	Cem. 3/1	DATE 20c. LO	CATION - City or SSVille			
	21. SIGNATURE OF FUNERAL SERVICE LICEN		addib Oi	22. NAME AL	D ADDRESS OF FA	CILITY				
	1 1000) Coud	-			neral Mome e. Dundal		,		
	23. PART I. Enter the diseases, or cor shock, or heart failure. Lis	nplications that caused at only one cause on er	the death. Do n					Approximata Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Ca	Amar	h				Onset and Death		
_		DUE TO (OR AS A	CONSEQUENCE OF	ጉ):						
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	7):						
CERTIFICATION	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF							
E	resulting in death) LAST			,						
	PART II. Other significant conditions	contributing to death bu	ut not resulting i	n the underlying	cause given in	Part I. 24a. WAS AN	AUTOBEY 2	4b. WERE AUTOPSY FINDINGS		
ICAL				·· ino anaonymy	, cause given in	PERFOR	IMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
MED						1 🗋 YES 2	NO	OF DEATH?		
ä	DID TOBACCO USE CONTRIL	BUTE TO CAUSE OF	F DEATH YE	S 🗆 NO 🗆	UNCERTAIN	10				
PHYSICIAN: MEDIC		HOSPITAL:	26. PLACE OF DEAT	OTHER:						
HYS	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM	E OF 28c. INJ	5 Desidence	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED			
ВУ Р	1 Astural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	URY WO	RK? 'ES 2 NO			1		
	3 Suicide 6 Could not be determined	26s. PLACE OF INJURY - building, atc. (Specif	— At home, term, s	treet, tactory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER:							e(a) and menner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM			ED (Mpnth, Day, Yjilâr)		
TO BE	11/2- 14	(30)			218	487	D 12	112/91-		
	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	-	Print) KLIN	- Sa	- DD-	215	27		
	MAR 1 4 1995	32. REGISTRAR'S SIGNA	TURE			1	- 10			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Item 17, g-721, 3-14-95, per f.h.,dr FOR STATE

		REGISTRAR		CERTIF	ICATE C	F DEATH	REG. N	10.		
		1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		1	TIME OF DEATN
			Craycor	n William	March	11 Cm	MONTH	DAY Y	YEAR	
					Marsik	111, 51.	March 7	, 1995		10:37 P m
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YE		7. DATE OF BIRTH	8.	BIRTHPL	ACE (State or Foreign
	i	213-07-2998	1-√2 M 2 □ F	94 YRS.	MONTHS DAT	TE HOURS MIN.	(Month, Day, Year)		Country)	11.
Shu Shu		9s. FACILITY NAME (If not institution, give s		74	AL		10/10/1		Virg	
2, 3 should	0				90. CITY, 10Y	VN OR LOCATION OF D	EATH	9c. COUNTY	Y OF DEAT	'N
3	ECTOR	Johns Hopkins Ba	avview Medic	cal Ctr.	Ba]	timore Ci	tv	N/	'A	
447	15									
Sec	1 #	10e. STATE 10b. COUNT	1	10c. CITY	, TOWN OR LO	CATION			10	d. INSIDE CITY
A.	DIR	Maryland	Baltimore			Dunda	1.k			LIMITS?
Ē	AL	10e. STREET AND NUMBER				10f, ZIP CODE		10- CITIZE		T COUNTRY?
8		2005 5 3	7							
5-0020 ending physician. as the burial-transit permit. Pages 1,	FUNER	3005 Dunleer Roa				21	222	Unite	ed St	ates
020 physician. burial-tram	5	11. MARITAL STATUS	12. WAS DECEDENT EVER	R IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify	Yee or No- 14	RACE -	American Indian,
02 Per p		1 Never Married 2X Married	FORCES? 1 YE	DATES	If you	, specify Cuben, Mexico YES 2 XNO Specific	en, Punrto Rican, atc.)			hite, etc.
21215-0020 If or attending physic for use as the burial-	₩	3 Widowed 4 Divorced			1	ies a Maro Specia	y.		Specify:	White
15 tend	ED	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	Hellat occum	ATION	I are while or			
12 use use	E	(Specify only highest grade	completed)	(Give kind of w	ork done during	most of working	TOD. KIND OF E	BUSINESS/INDUS	HT	
1 Ta 10	=	Elementary/Secondary (0-12)	College (1-4 or 5+)							
G bed	ا ا		4 Years	Electr	rical H	ngineer	Ele	vator		
AND 21 the hospital or detached for u	COMPL	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maid	en Sumeme)		
YLAND by the hospit be detached	6 111	-William Huston	Assehall Wil	liam Houston	Marsha	11	Sally Bel	10 MOFT	14700	
or band	B	19e. INFORMANT'S NAME (Type/Print)	MISHAIL			et end Number or Rural				
MARYLAND 212: retained by the hospital or att 5 should be detached for use	2		1 77							
		Mrs. Muriel Mars	snall	3005	Dunlee	er Road D	undalk, M	D 2122	22	
6 may ctor, pay	2	20e. METHOD OF DISPOSITION	2	Ob. PLACE AND DATE O	F DISPOSITION	(Name of	OATE 20c.	LOCATION - City	y or Town,	State
e 6 ma ector, p		1 Buriel 25 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	emetery crematory aret	her place)	Corp. 3/1	0/95	Towson,		
BALTIMORE, after death. Page 6 may be novel movel.	5	21. SIGNATURE OF FUNERAL SERVICE LIC		TATALOG DO	22 NAM	AND ADDRESS OF EA	CHUA	TOWNOTT	THAT	ylana
death. Pag tuneral dir					Duc	and address of fa a-Ruck Fu	neral Hom	e of Du	indal	k. Inc.
Al dea		Down FT	Dans.			22 Wise Av				
E 7 C 6		23. PART I. Enter the diseases, or o	complications that caus	ad the death. Do n	ot enter the	mode of dates and	e. Durida	TK, III	212	
5 = 2	2	shock, or heert failure.	Liet only one ceuse on	each line.	or enter the	mode or dying, suc	il as caldiec of les	piratory arrea	t,	Approximate Interval Between
		IMMEDIATE CAUSE (Final	C 00		^					Onset and Death
ation a		disease or condition resulting in death)	2000	· Cardise	CLED	th				MINUTE
68760, executed within 24 and completely fille o burial, cremation, matic event, the			OE TO (OR AS	A CONSEQUENCE OF):	the intrond	*			
		_	1 obse	Lie Dunan	Cm. Cal	INDONE				Minutes
OX 68 e be executed by sician and confort to bunish	CERTIFICATION	Sequentially list conditions,	DINE TO (OR AS	A CONSEQUENCE OF	Olbrida Con		0.4			7
BOX cate be en hysician a prior to	4	if any, leading to immediate cause. Enter UNDERLYING	552.15(0),775	A GONGEOGENGE OF	1.					
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Certificate ding physical physical control of the phys		thet initieted events	DUE TO (OR AS	A CONSEQUENCE OF):					
		resulting in death) LAST	1.							
S, P le death the atten Mental										
ORDS, that the dea ed by the att th and Menta	MEDICAL	PART ii. Other significent condition		but not resulting in	n the underly	ying cause given in	Part i. 24a, WAS	AN AUTOPSY		RE AUTOPSY FINDINGS
CORD res that the ligned by the ealth and h	일	VANKINGONS DIS	600				100	ORMEO?		MILABLE PRIOR TO MPLETION OF CAUSE
/ITAL RECO N: The law requires the ficate has been signed State Dept, of Health		Bashole Conce					1 _ YES	2 NO		DEATH?
REDE Seen Seen Seen Seen Seen Seen Seen See	Σ								1 [YES 2 NO
L REColaw requires as been sign Dept. of Healt	PHYSICIAN:	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YE	S NO	UNCERTAIN	V 🔲			
V: The icate ha	1	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	N (Check only o	ne)				
OF VITAL HYSICIAN: The law his certificate has with the State Deprived. or litem 23	S	EXAMINER?	HOSPITAL:	ripatient 3 DOA	OTHER:	iome 5 Paeldence	B C Other (Specific)			
Sicial Si]	27. MANNER OF DEATN	28e. DATE OF INJURY			INJURY AT	28d. DESCRIBE HOV			
	0	1 Natural 5 Pending	(Month, Day, Year)	INJU	JRY	WORK?	200. DESCRIBE HOP	INJURY OCCUR	IEU	
ON OP DING PHYS After this death with	B	2 Accident Investigation				YES 2 NO				
O NO NO		3 Suicide 8 Could not be	28e. PLACE OF INJUF building, etc. (Sp	RY — At home, term, st	treet, factory, o	ffice	281. LOCATION (Street	it and Number or i	Rural Route	Number,
DIVISION OF VITA DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate in hours after death with the State of them 28 is marked, or item	티빌티	4 Homicide determined		,			City or Town, Ste			
DIV DR A DIRECT PROURS		29e, CERTIFIER								
		(Check only	CIAN: To the best of my kno							
HOSPITAL FUNERAL WITHIN 72	5	2 MEDICAL EXAMINE	R: On the beele of examinat	ion and/or investigation	n, in my opinio	n, death occured at the	time, date end place,	and due to the c	euse(e) en	d menner es stated.
8 5 7 8	0	295 MONATURE AND TITLE OF CERTIFIER				20- LICENSE ANIA	1050	T 44 7 7 7 7 7		
THE fied Fied	8	1/m/41	ND			29c LICENSE NUN	NOCH .	3 /		nth, Day, Year)
668₹	2	- month				1)3643	0	1 2/	10/50	
_	-	NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF O	DEATN (ITEM 27) (Type	Print)			-		
()		JEFF MULTANOS	ON NO	21/2 0	Undal	h, So	ltimore	21111	2	l
7/2						1 3.	- / 7/12			
ν		MAR 1 4 1995	Julia d'Aust	sor Roylall						



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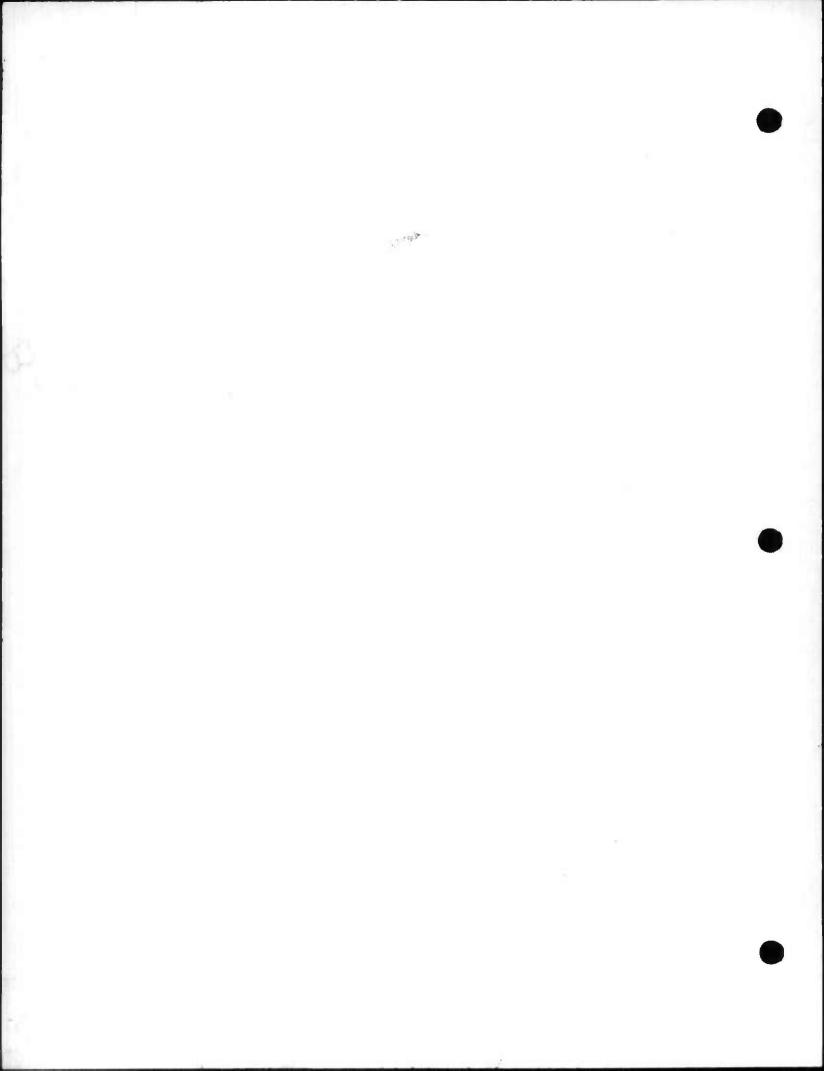
TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR				9	STATE OF	MARVI	AND /	DED	ADTMEN	IT OF HEA	ITM	AND	MENTAL	HYCIENE
ITEMS:	23	PART	Ι,	27,	28a-f,	PER M	1E0 F	ILM (G-721	3/24/95	t.t			

				1111110	ATE OF	PLAIII		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	E OF DEATH	NY	YEAR	3. TIME OF DEATH	
- 1		WILLIAM		LEY,		,	03	03 08 1995		5	2:47 A	
	4. SOCIAL SECURITY NUMBER	-5-4-5-	E (In yrs. last b	MC	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Mor	th, Day, Year)		8. BIRTHP Country)	LACE (State or Foreign	
	212-52-3660 9s. FACILITY NAME (If not institution, give	41	7	YRS.				.21,194	V		YLAND	
œ	The state of the s									ITY OF DE	ATH	
5	RESIDENCE OF DECEDENT BALTIMORE BALTIM										IORE	
DIRECTOR	10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									T	10d. INSIDE CITY	
	MARYLAND BAI	LTIMORE			ARBUT	rus				- I	LIMITS? 1 YES 2 [[] NO	
AL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF W										21	
EB	1217 LEEDS TERRAC	CE				212	27		J	J.S.A	١.	
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	If yes, sp	DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American India Black, White, etc. 15. Specify: 16. RACE — American India Black, White, etc.					White, etc.				
	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECE	DENT'S US	UAL OCCUPATION	ON	16	b. KIND OF BU	INESS/INDU	USTRY		
ᇦ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	kind of work o NOT use re	done during mo tired.)	ost of working						
MP	12TH GRADE		TR	UCK I	DRIVER			SELF-E	MPLOY	YED		
COMPL	17. FATHER'S NAME (First, Middle, Last) TOUN FINIA DID MODI EST											
BE	JOHN EDWARD MOBL	.EY				CATHER	INE V	VRIGHTS	ON			
0	19a. INFORMANT'S NAME (Type/Print)					and Number or Run				Code)		
7	MRS. JOAN HARKUM		39	07 Ht	JDSON S	TREET -	BAL	'IMORE,	MD	212	44	
	20g_METHOD OF DISPOSITION 1	noval from State	Ob. PLACE AND	DOATE OF D	ISPOSITION (Ne	eme GARDEN	S DA		CATION — C			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE # # 22. NAME AND ADDRESS OF FACILITY											
	▶ Jackie &	1 //	nor	_	HUBBAR	D FUNER	AL HO			r MD	21220	
	disease or condition resulting in death) MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF):										Onset and De	
NO.	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
RTIFICAT	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	cDUE TO (OR AS	A CONSEQUE	ENCE OF):								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	d										
DICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	d			he Underlying	g cause given i	n Pert I.	24a. WAS AN PERFOR 1 YES 2	MED?	6	WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	d	but not rea	ulting in t				PERFOR	MED?	6	COMPLETION OF CAUSE	
AN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	da contributing to deeth	but not real	ulting in t				PERFOR	MED?	6	WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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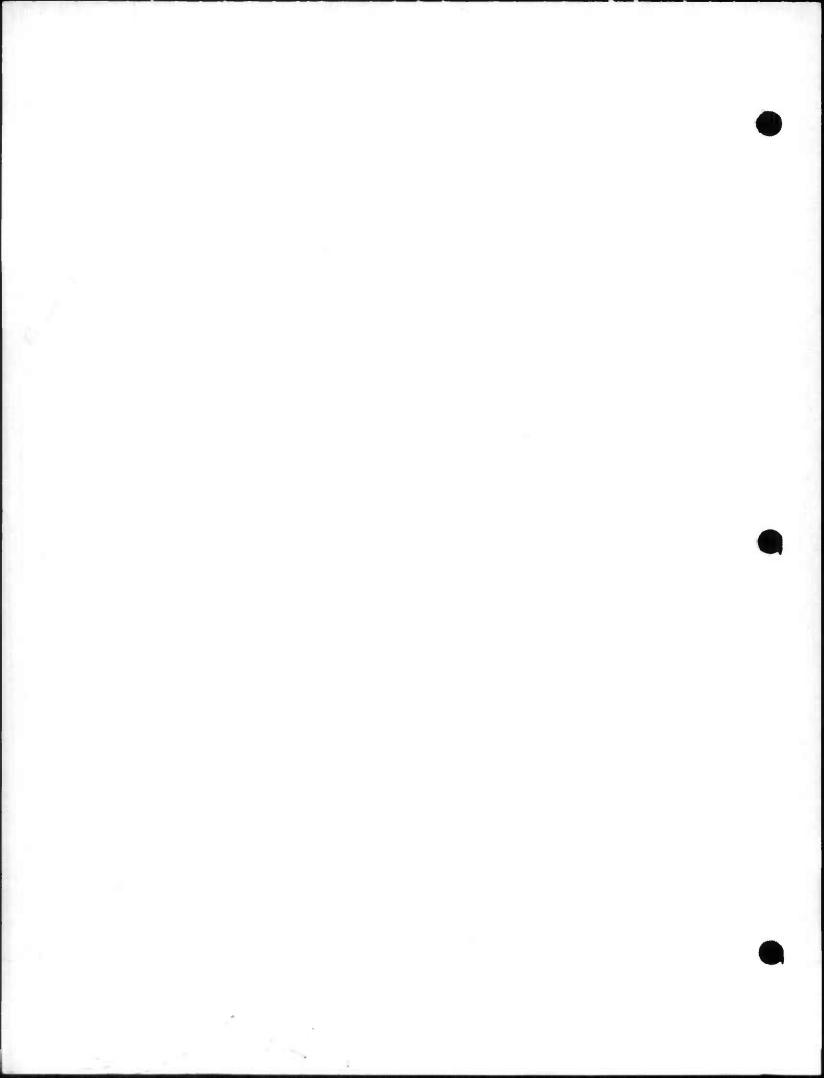
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a nours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached he find within 70 hours after death with the State perin of Health and Mental Honison notion for immoral	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,
ined by	onld be	fied at
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THE HO	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the last within 72 hours after death, with the State Deer or Health and Mental Honsone orion to brind incomation or removal	PORTA
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STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	IENE
		C	ERTIFICATE	0	F DEAT	H		REG	NO

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, L	H. Michaels, S	n			2. DATE OF DEATH	Ž. 199	3. TIME OF DEATH 10:41 P. M
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.1	BIRTNPLACE (State or Foreign
1	108 32 4234	1 💢 💥 2 🗆 F	53 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) ec 21 19		Country)
œ	90. FACILITY NAME (If not institution, g NORTH ARUNDE:			GLEN BU	DNTE	ITN	9c. COUNTY	OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COI		10.00	TOWN OR LOCAT			A.A.C	
DIRE		ne Arundel		vern	ION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
3AL	100. STREET AND NUMBER	a c+		101	. ZIP CODE 2114	1	10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	1816 Graybir	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC		C ORIGIN? (Specify Yea	or No.— 14.	RACE — American Indian,
BY F	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 TYPES	2 NO ATES		ecify Cuban, Maxican,			Black, White, atc. Specify:
	15. DECEDENT'S	1964 197 EDUCATION	16a. DECEDENT'S	JSUAL OCCUPATION	ON _	16b. KIND OF BUS		White
COMPLETED	(Specify only highest g	College (1-4 or 5+)	life. Do NOT use	111	st of working	Cmaga		
OMP	1 2 17. FATHER'S NAME (First, Middle, Last,)	F'ood	clerk	16. MOTNER'S NAM	Groce E (First, Middle, Maiden		
BE C	Leroy Michae	ls				zel Mart	,	
5	19a. INFORMANT'S NAME (Type/Print) Melvenia M	ichaolc				, Severr		
	20a, METHOD OF DISPOSITION	201	PLACE AND DATE O	F DISPOSITION (Na		DATE 20c. LO		or Town, Stata
	→ Burlal 2 Cremation 3 1 1 4 1 Donation 5 1 Other (Specify)		retery, crematory or other. Linc	coln Ce	emetery		entwoo	od, Md
	· Batrel A	Const!		Hard	lesty Fu	neral Ho		P.A. 851 Md21054
	23. PART i. Enter the diseases, shock, or seert faile	or complications that cause ire. List only one cause on a	d the death. Do n	ot enter the mo	de of dying, such	ss cardisc or respi	ratory srrest	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ASCVD							
z	DUE TO (OR AS-A CONSCIUENCE OF):							
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	DUE TO (OR AS A CONSEQUENCE OF):					
SEL	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF):				
EE	resulting in death) LAST	d						
A	PART II. Other mignificent condi	tione contributing to death b	out not reaulting in	the underlying	ceuee given in P	Part i. 24s. WAS AN PERFOR	AUTOPSY	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC	-					1 YES 2	NO	OF DEATH? 1 YES 2 NO
N. N	DID TOBACCO US		CAUSE OF	DEATH Y	ES NO			T C TES 2 C NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMPLER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out		OTHER:	ACE OF DEATH (Chec			
ЭНХ	27. MANNER OF DEATN	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ	e 5 Rasidenca 8 URY AT RK?	Other (Specify) 28d. DESCRIBE NOW II	NJURY OCCUR	ED
ВУ	1 Maturel 5 Pending 2 Accident Investigati	on		M 1 🗆 1	rES 2 NO			
ETE	3 Suicide 6 Could not 4 Nomicide detarmine		cify)	reet, tactory, office		28f. LOCATION (Street a City or Town, State)	and Number or F	Rural Route Number,
COMPLETE		NYSICIAN: To the best of my know						
	266. SIGNATURE AND TITLE OF CERT	WINER: On the basis of examination	n and/or investigation	ı, in my opinion, d				
TO BE	Illey Bru	day MA			D280	640	► 3/	13/95 Day Hear)
777	556 Cardin	WHO COMPLETED CAUSE OF DE	saderia i	WA 21	122			
	SI. DATE FILED (Month, Day, War)	July DEWISION A	ATYRE	0.1				
	MAR 1 4 1995	July	78 (63) £					



BALTIMORE, MARYLAND 21215-0020

BOX 68760 P.O. DIVISION OF VITAL RECORDS,

permit. Pages 1, 2, 3 should use as the burial-transit retained by the hospital or attending physician. 5 should be detached for use as the burial-tran To notified page 5 s hours after death. Page 6 may be must be funeral director, examiner filed in by the medical 8 品 completely traumatic event, in and com to hurse, o been signed by the attending physiciem tt. of Health and Mental Hygiene prior it requires that the death certificate be other 0 shows any has be Dept. 23 HOSPITAL OR ATTENDING PHYSICIAN: The law Item certificate t 10 marked, this c After 28 is DIRECTOR: / TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2

31. DATE FILED (Month, Day, Year)

4 1995

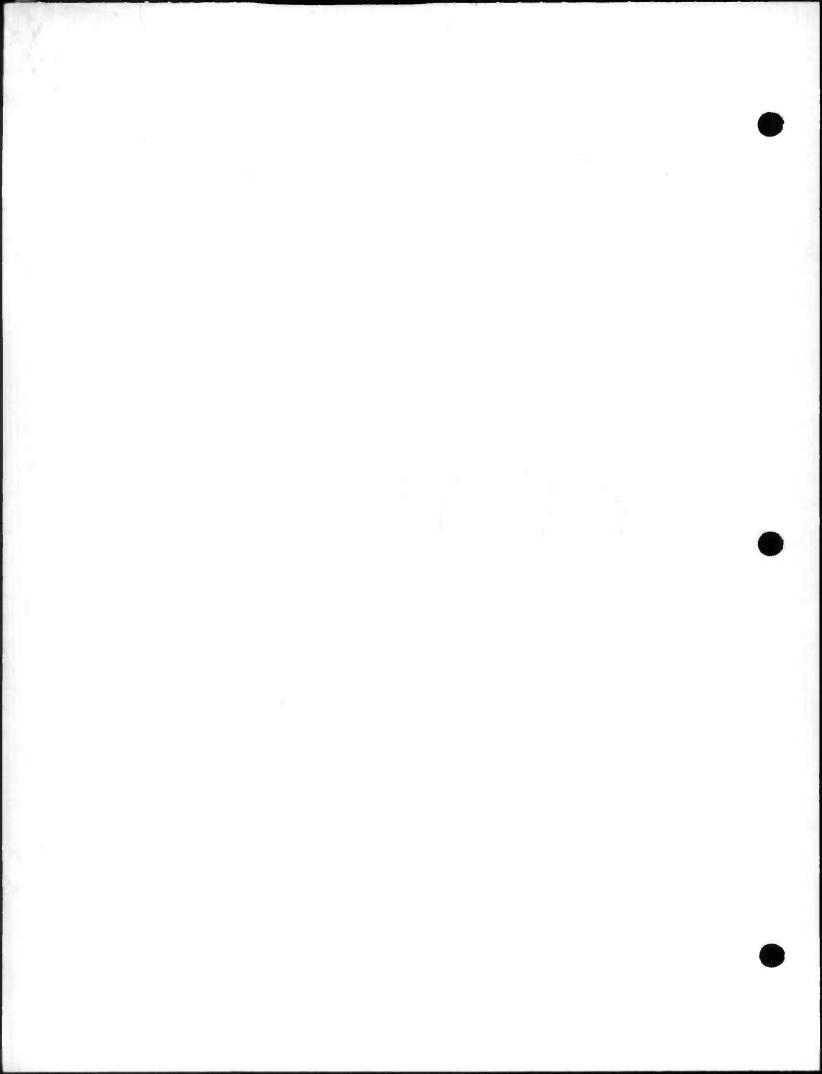
32. REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 95 0.3 Mazel Matthews 10 3:17 a 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217,20-4314 1/14/1927 HOURS 1 M 2 X F 68 YRS Balto., Md. 90. FrailLITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harbor Hospital DIRECTOR Baltimore n/a RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland n/a Baltimore 1 X YES 2 NO 10a. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 6564 Booker Avenue 21060 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried It yee, specify Cuben, Mexican, Puerto Rican, atc. 1 TYES 2 X NO Specify: BΥ Specify: 3 Widowed 4 Divorced Black 16a. DECEDENT'S USUAL OCCUPATION

16a DECEDENT'S USUAL OCCUPATION

16a DECEDENT'S USUAL OCCUPATION

16a DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig. (Give kind of work done life. Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5+) Mass Transit Adm. 12th Motor Pool 5 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) William Partlow BE Bessie Partlow 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Matthews 6564 Booker Avenue Balto., Md. 21060 20a. METHOD OF DISPOSITION 1 N Burial 2/口 Cremation 3 口 20b. PLACE AND DATE OF DISPOSITION (Name of 3/15 DATE 20c. LOCATION — City or Town, State cemetery, crematory or oth Garrison Owings Mills, Md. Other (Specify) Forest Vet. Cem 21. SIGNATURE di FUNERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBRRTY HEIGHTS AVENUE 23. PART V omplications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, list only one cause on each line. k, or heart fal interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition Sudden Death 30 min resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Ventricular Dysrrythmea CERTIFICATION 35 min Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING Hypertensive Heart Disease 10 yrs CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST Hypertension 20 yrs PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Insulin Dependent Diabetic, Seizures 1 TYES 2X NO OF DEATH? Pyelonepuritis 1 YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 XYES 2 NO Inpatient 2 - ER/Outpatient 30 DOA 4 ☐ Nursing Nome 5 D Residence 6 ☐ Other (Specify) 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 12 Natural 5 Pending 1 YES 2 NO B 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be datermined COMPLETED 4 Nomicide 29e. CERTIFIER 12 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 2 MEDICAL EXAMINER: On the of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIE BE 29c_LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, Mulle 2

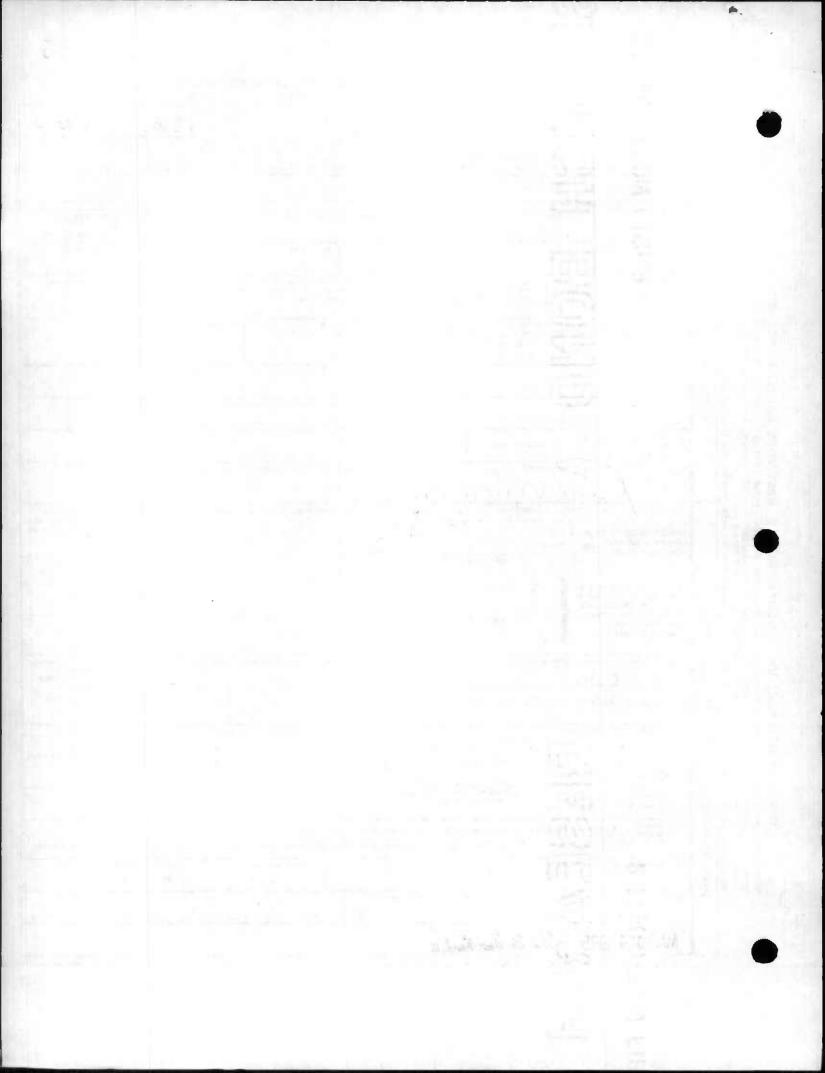


BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physicia	PHRECTOR After this partificate has been signed by the attending physician and completely filled in by the funeral diseases a should be deteched for use as the business
	hours after de	filled in hy the fi
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	equires that the death certificate be executed within	an signed by the attending physician and completely
DIVISION OF VITAL R	L OR ATTENDING PHYSICIAN: The law re	DIRECTOR. After this certificate has hes

al or attending physician. for use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hos TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARY	YLAND / DEPARTI	MENT OF HEALTH AN	D MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, L	bert Nie	Isen		2. DATE OF DEATH	DAY ASYEA	3. TIME OF DEATH 4:30 P	
	4. SOCIAL SECURITY NUMBER 579-09-4851 9a. FACILITY NAME (If not institution, gr	579-09-4851 5√2 M 2 □ F 75 YRS. MONTHS DAYS HOU			N. (Month, Day, Year) Dec. 22, 19	919 Mai		
TOR	ANNE ARUNDEL MEDICA	L CENTER		ANNAPOLIS	P DEATH	ANNE AF		
DIRECTOR	10a. STATE 10b. COL			OWN OR LOCATION DEALE	12 - 2	10d. INSIDE CI LIMITS? 1 ☐ YES X R		
FUNERAL	P.O. BOX 610			10f. ZIP CODE 20751		16g. CITIZEN C	OF WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 XX Merried 3 Divorced	12. WAS DECEDENT EVE FORCES? 1\footnote{\text{Y}} \text{Y} Y IF YES, GIVE WAR OF	R IN U.S. ARMED ES 2 NO R DATES	13. WAS DECENDENT OF HI If yes, specify Cuban, M 1 YES 2 XXND S	exican, Puerto Rican, etc.)	8	ACE — American Indian, ilack, White, atc. pecify: WHITE	
COMPLETED	15. DECEDENT'S (Specify only highest g	EDUCATION rade completed) College (1-4 or 5 +)	16a. DECEDENT'S US (Give kind of word life. Do NOT use n	done during most of working	16b. KIND OF B	USINESS/INDUSTR	γ	
MPL	12	Ø	SELF EMPLO			RTY MANAGE	EMENT	
BE CO	17. FATHER'S NAME (First, Middle, Lest) WILLIAM GOLDMAN				S NAME (First, Middle, Melde NCE E. SHELLEY			
5	19a. INFORMANT'S NAME (Type/Print) CAROL ANN SNYDER-NI	ELSEN		DRESS (Street and Number or A DX 610, DEALE,				
	20s. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 6 4 Donation 5 Other (Specify)	Removal from Stats	20b. PLACE AND DATE OF I cometery, cremetory or other BALTIMORE WASH	Plece)	y B/9 LAU	OCATION — CHY O	AND	
	22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707							
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. DUE TO (OR A	S A CONSEQUENCE OF):	VA	auch as cardiac or res	piratory arreat,	Approximata Interval Batwee Onset and Deat	
ENILLI	CAUSE (Disesse or Injury that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQUENCE DF):					
PHYSICIAN: MEDICAL C	PART II. Other significant condi	tions contributing to deat	h but not resulting in	the underlying cause give	n In Part I. 24a, WAS A PERF	ORMED?	24b. WERE AUTOPSY FINDINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATH				
- 1	27. MANNER OF DEATH 1 Natural 5 Pending	28s. DATE DF INJUF (Month, Day, Vea	TY 28b. TIME C	Nursing Home 5 Reside F 28c. INJURY AT WORK? M 1 YES 2 NC	28d. DESCRIBE HOW	INJURY OCCURE)	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)					rel Floute Number,		
COMPLE		HYSICIAN: To the best of my kr					se(s) and manner as stated.	
IO BE C	29b. SIGNATURE AND TITLE DF CERT	Dagle Quele	no mo	29c. LICENSE	NUMBER +3 236	29d. DATE SIGN	NED (Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON	who completed cause of	DEATH (ITEM 27) (Type, Pr	no)	te 120 A	napolis	mo 21401	
	MAR 1 4 1995	32. REGISTRAR'S SI	GNATURE	3				

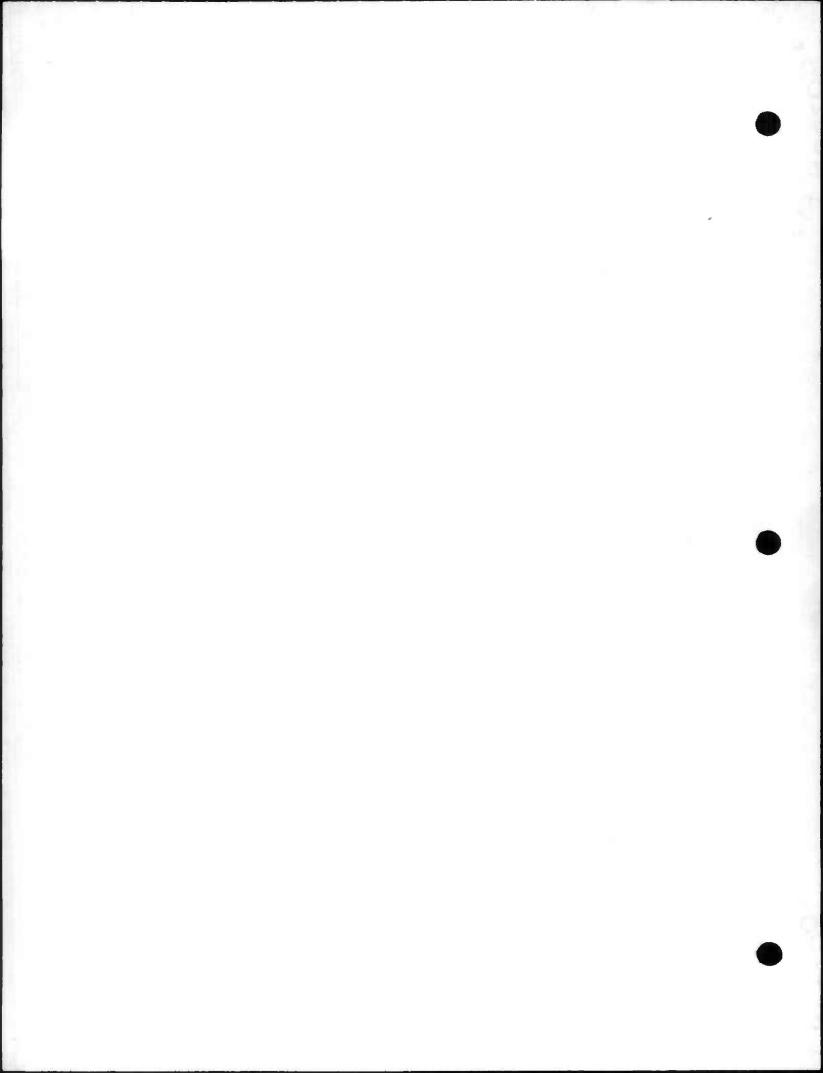


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

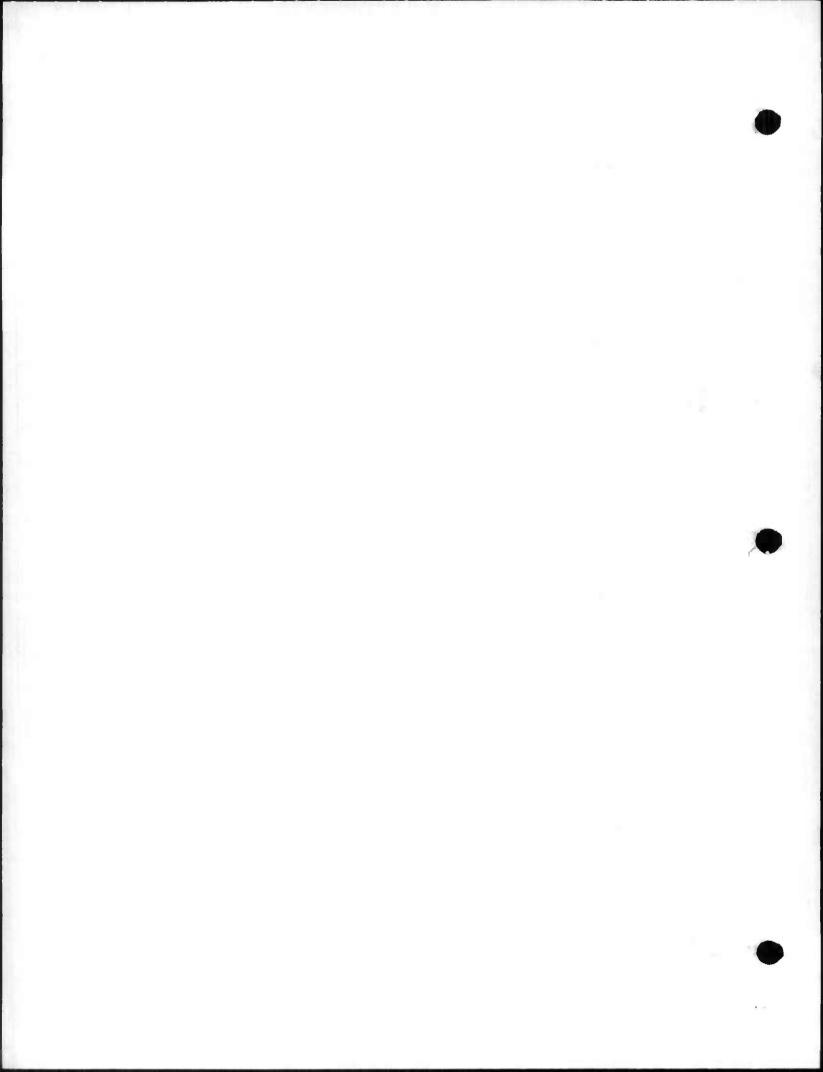
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest) Willie I.ee McRae 2. Date Of Death Month 03 07 95							
	243-22-1670 1X M 2 🗆 F	A 2 \square F 74 YRS. MONTHS DAYS HOURS MIN. $5-6-19$ dil						
TOR	99. FACILITY NAME (If not institution, give street and number) 4701 Hamilton Avenue RESIDENCE OF DECEDENT	96. CITY, TOWN OR LOCATION OF DE Baltimore		N/A				
IRECTOR	10a. STATE 10b. COUNTY Maryland N/A	Baltimore		10d. INSIDE CITY LIMITS?				
ERAL DI	10a. STREET AND NUMBER	10f. ZIP CODE	10g. CITI	1 1 YES 2 □ NO ZEN OF WHAT COUNTRY?				
FUNER	4701 Hamilton Avenue 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U	21214 J.S. ARMED 13. WAS DECENDENT OF HISPAN	IIC ORIGIN? (Specify Yee or No	U.S.A 14. RACE — American Indian.				
₽	1 Never Married 2 Merried 3 Wildowed 4 Divorced FORCES? 1 YES IF YES, GIVE WAR OR DATE 12/29/42 1	2 NO If yes, specify Cuben, Mexica 1 YES 2 NO Specify 1 YES 2 NO Specify	n, Puerto Rican, etc.)	Specify: Black				
LETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/IND	2.77.47				
once. COMPLET	12 17. FATHER'S NAME (First, Middle, Last)	Meathandler 18. MOTHER'S NA	Kavanaugh ME (First, Middle, Meiden Surneme)	ı's				
BE C	Walter McRae		ie Bell					
To let	Willie Mae Murray	19b. MAILING ADDRESS (Street and Number or Rural II 4918 Crenshaw Ave.		21206				
must	1 2 Buriel 2 Cremation 3 Removal from State Compte	LACE AND DATE OF DISPOSITION (Name of ery, orematory or other place) TISON FOREST Vet. 3	DATE 20c. LOCATION —					
medical examiner must be notified at once. TO BE COM	II. BIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA	CILITY	eral Home Inc				
nt, the medica	resutting in dasth)	ha death. Do not enter the mode of dying, such hilne. Manary arvest	h as cerdiac or respiratory arm	est, Approximate Interval Batwean Onset and Death				
injury, or other traumatic event, the	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): At the resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): C. Uppling Vhenmatid Guthrifis.							
CERT	resulting in death) LAST							
EDIC/	PART II. Other aignificant conditions contributing to death but News I nic Sundule	not resulting in the undarlying cause given in Colon Canch.	Part I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
23 shov	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES NO UNCERTAIN	10	1 TYES 2 NO				
or item 23 s YSICIAN:	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetie	OTHER:	8 Other (Specify)					
is marked, or D BY PHY	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCC	URED				
2 2	4 Homicide datermined building, etc. (Specify)	At home, ferm, street, lectory, office	28I. LOCATION (Street and Number City or Town, State)	or Rural Route Number,				
MPORTANT: If item O BE COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beat of my knowled one) 2 MEDICAL EXAMINER: On the basic of axamination e	igs, death occurred at the time, date end place, end due and/or investigation, in my opinion, death occured at the						
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	29c, LICENSE NUN	19 3 9 29d. DATE	SIGNED (Month, Day, Year)				
ľ	MUAN WISTER,	H8; GWALL	ER AVE;	BALTIMORE				
	00 09 (95 MAR 1 4 1995 J	the Davidson Randall	/ (DHMH-18 Rev 1/89				



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	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)				DEATH	2. DATE OF DEATH		3. TIME OF DEATH	
	MARY N. NOOSE						0, 199	EAR	
			n yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTNPLACE (State or Foreign	
	-10 20 1730	□ M 2 🟋 86	YRS.	MONTHS DAYS	HOURS MIN.	JULY 29,1		ORTH CAROLINA	
_	9e. FACILITY NAME (If not institution, give street	t and number)		9b. CITY, TOWN	OR LOCATION OF D		Sc. COUNTY		
DIRECTOR	NORTH ARUNDEL HOSPI	[TAL		GLEN	BURNIE		ANNE	ARUNDEL	
EC.	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION			10d, INSIDE CITY	
DIR	MARYLAND BALTIM	MORE CITY		BAT.	TIMORE			LIMITS?	
AL	10a, STREET AND NUMBER				ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	431 THORNFIELD ROAD)			2122	9	U.S.	Α.	
ž	11. MARITAL STATUS 12 1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Specify Yes		RACE — American Indian, Black, White, atc.	
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 XNO Specif			Specify:	
	15. DECEDENT'S EDUCAT	ION	16a. DECEDENT'S	USUAL OCCUPATION	ON .	16b, KIND OF BUS	EINESS/INOLIST	WHITE	
ET	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of v	vack done during ma	st of working	100. (1110 0) 000	MVE33/1140031	91	
APL	11TH GRADE		CLERK			GLENN I	L. MAR	ΓIN	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Sumeme)		
BE	THADEUS NEWSOME				MAVIS			Acres 15	
2	19a. INFORMANT'S NAME (Type/Print) WILLIAM D. NEWSOME					Route Number, City or Town			
.	204, METHOD OF DISPOSITION					RANDALLSTO			
	1 A Buriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	I from State 20b.	PLACE AND DATE Of the PLACE AND DATE OF THE	of DISPOSITION (Ne ther place)	me of		CATION — City	or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICENS		1	22. NAME AN	O AODRESS OF FA	3/14 BAL	LIMURE		
	> Xour	X KI	w			AL HOME, II			
	23. PART I. Enter the diseases, or com	nolications that caused	the death, Do o	410/ 1	VILKENS A	AVENUE-BAL'	I'IMORE,	, MD. 21229	
	ahock, or haart failura. List IMMEDIATE CAUSE (Final	t only one cause on ea	ch line.	ot arrier me mo	do or dying, suc	ii aa cardiac or respi	raiory arrest,	intarval Between	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CONGESTEUS /FRAT FASLURS DUE TO (OR AS A CONSEQUENCE OF):								
	resulting in death) / a	DUE TO (OR AS A	CONSEQUENCE OF):	17264			YEARS	
N	Sequentially list conditions, If any, leading to immediate one of the library								
ATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (ON AS A CONSEQUENCE OF): 4 ALS YEARS DUE TO (ON AS A CONSEQUENCE OF): 4 ALS YEARS DUE TO (ON AS A CONSEQUENCE OF): 4 ALS YEARS								
FIC	CAUSE (Disease or Injury that initiated events	DUS TO FOR AS A	SONSEQUENCE OF	CE(UR)	71477	2NU		YEARS	
CERTIFICATION	resulting in death) LAST	HYDERT	PUSTEM)				YEARS	
	PART II Other significant conditions of	and with visit on the state to						74143	
CAL	PART II. Other eignificant conditions of		not resulting I	n the underlying	cause givan in	Part I. 24a, WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDIC		ic/ The	u Crypny	y USES	3738	1 🗆 YES 2	₫ NO	DF DEATH?	
Σ	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	DEATH VE	CELNOT	LINICEDTAL			1 TES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEAT		UNCERTAIL	1			
SIC		IOSPITAL:		OTHER:	e 5 - Residence	6 Other (Specify)			
¥	27. MANNER OF OEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI	OF 28c. INJ		28d. OESCRIBE NOW II	JURY OCCUR	E0	
BY	1 W Netural 5 Pending 2 Accident Investigation	(WORN, Day, Idan)	11431		ES 2 NO				
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	- At home, ferm, a	treet, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or R	tural Route Number,	
ETE									
COMPLET		N: To the best of my knowle							
Ö	2 MEDICAL EXAMINER: C	On the beele of examination	and/or investigation	n, in my opinion, d	eath occured at the	time, date end place, end	I due to the ce	use(e) and manner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	ABER	29d. DATE SIG	GNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WNO CO	COMPLETED CALLED OF STA	TM (ITPM	0.1.11	D17	771	3/	10/95	
	DAID P - H O	SHOW CAUSE OF DEA	1 7 A		0-	E GLENBUR	,	MARKENED	
	31. DATE FILED (Month, Day, Joseph OC	SUPTE SUC	MENTALL	1 BP+M	C BRIV	E CLENDSON	NE	21061	
	MAR 1 4 1995	Jana an municipa	S COLORNAL						



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest)	TOATE OF		REG. NO.		3. TIME OF DEAT	N	
	Martha Lucenia Nahatzki		l I	Month	1995	5:30	ан	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR		DATE OF BIRTH (Month, Day, Year)		IPLACE (State or Fo	reign	
	212-40-5550 1 □ M 2 🖁 F 84 YRS.		M	arch 26,	1910 Mar	yland		
œ	9e. FACILITY NAME (If not institution, give street and number)		R LOCATION OF OEATI	N	9c. COUNTY OF E			
5	Edenwald Care Center	Towson			Baltim	ore		
DIRECTOR		TY, TOWN OR LOCAT	ION			10d, INSIDE CITY		
	Maryland Baltimore To	wson				1 TYES 2 X	NO	
FUNERAL	A CONTRACT OF A CONTRACTOR		ZIP CODE		10g. CITIZEN OF			
UNE	800 Southerly Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED		1286 ENDENT OF HISPANIC	DRIGIN? (Specify Ves.)	U.S.A	- American India		
	1 Never Merried 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If yes, spe	clfy Cuben, Mexican, P			k, White, etc.		
D BY	3 Wildowed 4 Divorced					white		
COMPLETED	(Specify only highest grade completed) (Give kind of	S USUAL OCCUPATIO work done during mos use retired)		16b. KIND OF BUSI	NESS/INDUSTRY			
PL	Elementary/Secondary (0-12) College (1-4 or 5+) 4 years Teache			Schools				
Š	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME	(First, Middle, Maiden St	urneme)			
BE (James Morris Smith		Julia]	Maas		
5			nd Number or Rural Rout					
	William McLean 9 Aig 200. METHOD OF DISPOSITION 20th PLACE AND DATE		ad Towson,					
	1 Burlet 2 M Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) Greenmount	other plece)	me of March	15 Roll	ATION — City or To	wn, state Maryland	,	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AN	O ADDRESS OF FACILI	TY		riar y ranc	-	
	Muns Joseph Back		ell-Wiedef			1 010		
	23. PART I. Enter tha diseases, or complications that coused the death. Do	not anter tha mod	York Road,	BALLIMOY s cerdiac or reapire	e, Mary.	Approxima		
	shock, or heart feliure. List only one cause on each lina. IMMEDIATE CAUSE (Final	10.	/ \			interval Ba Onset end		
	disease or condition resulting in death)							
_	DUE TOYON AS A CONSEQUENCE OF).							
<u>o</u>	Sequentially list conditions, If any, leading to immediate	M: O	ropper	71	OFE) a	(7)	
8	CAUSE (Disease or Injury	dent	re de	sery		104	4	
	thet initiated events resulting in death) LAST	DF):	A b			3!	,	
CERTIFICATION	- myest	we fee	m f	tillhe		19	5	
A	PART II. Other significant conditions contributing to death but not resulting	In the underlying	cause givan in Par	t I. 24a. WAS AN AI PERFORM		WERE AUTOPSY FIR		
음				1 TES 2		COMPLETION OF CO		
M			/	_		1 _ YES 2 _ N	10	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y	TN (Check only one)	UNCERTAIN					
SICI	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA	QTHER:	5 Residence 6	3 00 - 10 - 11 -			-	
Ϋ́	27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIM	E OF 28c. INJU	JRY AT 28	d. DESCRIBE NOW INJ	URY OCCUREO		\dashv	
BY	1 Accident Investigation	JURY WOF	ES 2 NO				[
ED I	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, tarm, building, etc. (Specify)	atreet, fectory, office	28	t. LOCATION (Street and City or Town, State)	d Number or Rural F	loute Number,		
E	an appropriate (1)							
COMPLET	(Check only Check only PHYSICIAN: To the best of my knowledge, death occurr							
	one) MEDICAL EXAMINER: On the basis of examination and/or investigation 29b. SIGNATURE AND TITLE OF CERTIFIER	on, in my opinion, oa					eted.	
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2	30. NAME AND AGORESS OF PERSON WHO COMPRETED CAUSE OF GEATH (THEM 27) (THE	S O	0 50v	40-1	RIV	2000	丌	
	31. DATE FILED Many both COLD 32. REGISTRANS SIGNATURE	0	700	, war y	01 10	Wille		
	MAR 1 4 1995 Julia Standar Randoll							

2. DATE OF DEATH MONTH

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31. DATE FILEO (Month, Pay.

1. DECEOENT'S NAME (First, Middle, Last)

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7. DATE OF BIRTH (Morth, Day, Yber) March 3,1919 214-01-6495 DAYS HOURS 1 M 2 XX 76 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Pages 1, 2, 3 Johns Hopkins Bayview Baltimore RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 3810 Hudson Street 21224 burial-transit Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried 1 TYES 2 X NO BY Specify 3 Widowed 4 Divorced page 5 should be detached for use as the ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) COMPLI Checker A&P (Super Fresh) notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Phillip Oberlander Mary Sommeth 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Oberlander 3810 Hudson Street Baltimore, MD 21224 pe 20s. METHOD OF DISPOSITION

\$ Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must n by the funeral director, removal. Cametery, crematory or other place)
Oak Lawn Cemetery 3/15/95 examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler, Inc. Funeral Home wabith 700 S. Conkling Street Balto., MD 21224 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and completely filled in by burial, cremation, or remo shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition HYPOXEMIA resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF) PNEUMONIA CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if sny, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any HEART FAILUNE CONGESTUR 1 - YES 2 NO has been Dept. of H PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) r this certificate h HOSPITAL: OTHER: 1 TES 2 NO 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 6 27. MANNER OF OEATH 28a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural м DIRECTOR: After the hours after death with them 28 is mark 1 YES 2 NO BY Investigation 2 Accident 26s. PLACE OF INJURY — At home, term, atreet, tactory, office building, atc. (Specify) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29s. CERTIFIER
(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attend. FUNERAL I within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: IS 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 95014 Tel MO 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VAHAKN SHAHINIAN JOHNS HOPKINS BAYVIEW MEDICAL CENTER. 32. HE CISTINA'S SHATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

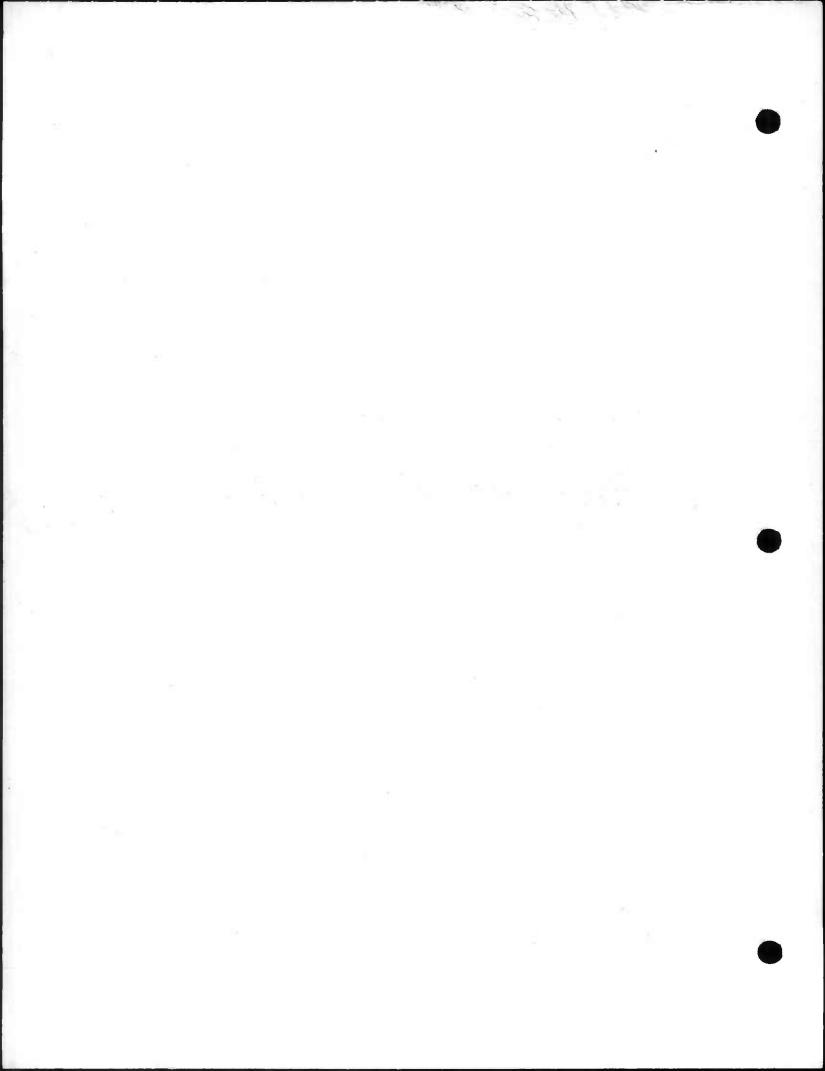
CERTIFICATE OF DEATH

IF UNDER 1 YEAR

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5. SEX

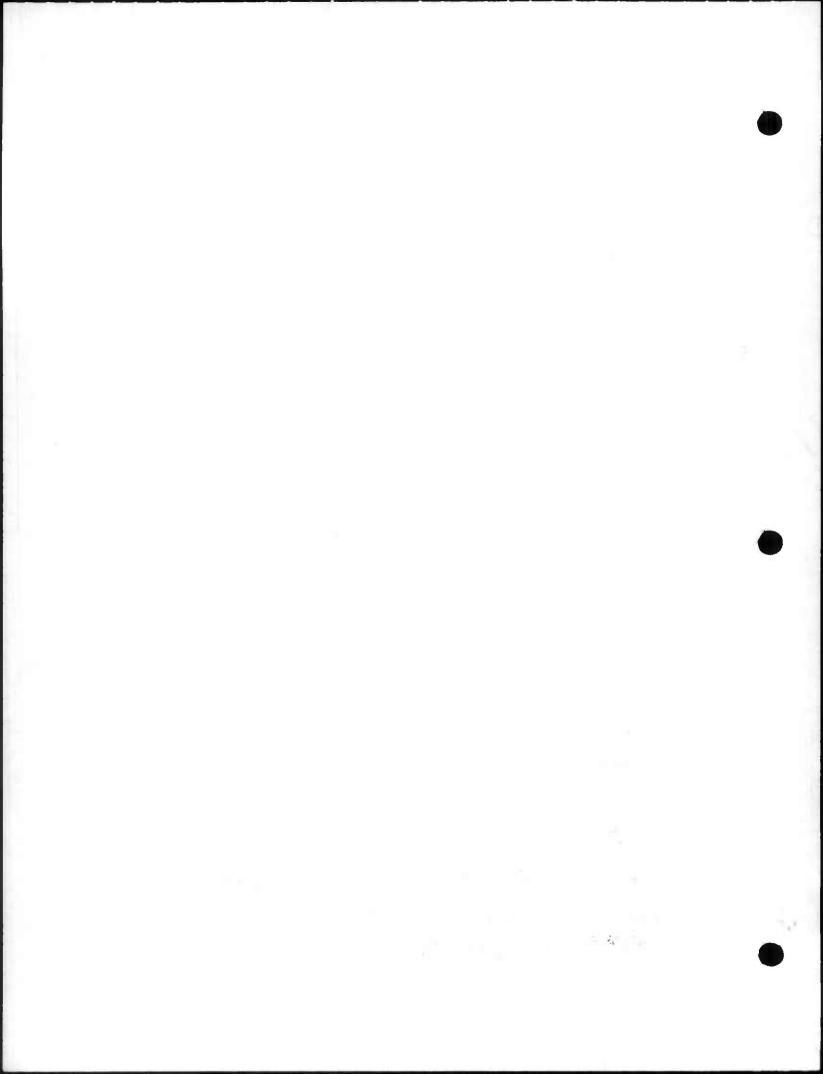
3. TIME OF DEATH 1220 AMM 6. BIRTHPLACE (State or Foreign Maryland 9c. COUNTY OF DEATH 10d. INSIDE CITY 1X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian. Black, White, atc. Specify: White 20c. LOCATION — City or Town, State Baltimore, MD Interval Between **Onset and Death** 24b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d, DATE SIGNED (Month, Day, Year)



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he law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician. This been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be better the anti-burial permit permit. Pages 1, 2, 3 should not the attending physician and completely filled in the funeral move.		23. PART i. Ente ahoc
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ician: The serificate h the State C or Item	IYSICIAN:	25. WAS CASE REFE EXAMINENT 1 VES 2
PHYSICIAN: The this certificate h with the State C	PHYSICIAN:	25. WAS CASE REFE EXAMINEN?
ING PHYSICIAN: The Wife this certificate heath with the State Caracter, or Nem	BY PHYSICIAN:	25. WAS CASE REFE EXAMINENT: 1 1 TES 2 1 27. MANNER OF DE 1 1 Metural 2 Accident
TENDING PHYSICIAN: The DR: After this certificate h for death with the State E is marked, or item	ED BY PHYSICIAN:	25. WAS CASE REFE EXAMINET? 1 VES 2 27. MANNER OF DE
R ATTENDING PHYSICIAN: The RECTOR: After this certificate hours after death with the State I'm 28 is marked, or Nem	ETED BY PHYSICIAN:	25. WAS CASE REFE EXAMINER? 1 VES 2 27. MANNER OF DEJ 1 Nettral 2 Accident 3 Suicide 4 Homicide
IAL DR ATTENDING PHYSICIAN: The AL DIRECTOR: After this certificate h 72 hours after death with the State I If Item 28 is marked, or Item	MPLETED BY PHYSICIAN:	25. WAS CASE REFE EXAMINER? 1 VES 2 27. MANNER OF DE 1 Mettral 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER 1
OSPITAL DR ATTENDING PHYSICIAN: The INERAL DIRECTOR. After this certificate hithin 72 hours after death with the State ENT. If Hem 28 is marked, or Hem	COMPLETED BY PHYSICIAN:	25. WAS CASE REFE EXAMINER? 1 VES 2 27. MANNER OF DE 1 Letter 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		ENT OF HEALTH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH				
	Francis Hamilton	O'Connor			March 7	1995	7:00 P M				
	4. SOCIAL SECURITY NUMBER 5	. SEX 6. AGE (In)		INDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	HPLACE (State or Foreign					
	214-34-4882	X M 2 □ F 5	9 YRS. MON	THE DAYS HOURS MIN.	September 9.	Coun	ryland				
	9e. FACILITY NAME (If not institution, give street	t and number)	9b.	CITY, TOWN OR LOCATION OF D		9c. COUNTY OF					
OR	6544 Montgomery	Road		Elkridge		Howard					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY					110110110					
E .				WN OR LOCATION			10d, INSIDE CITY LIMITS?				
	190. STREET AND NUMBER	oward	Elkr				1 TYES 2 X NO				
RA		Dood		101. ZIP CODE			WHAT COUNTRY?				
FUNERAL	6544 Montgomery			21227		US	Α				
교	1 Never Married 2 Merried	2. WAS DECEDENT EVER IN U. FORCES? 1 YES	2X NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.)	or No — 14. RAC Blac	E — American Indian, ek, White, atc.				
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	S	1 YES 2Y NO Speci	fy:	Spec	white				
<u></u>	16. DECEDENT'S EDUCAT	ION 16	ia. DECEDENT'S USU.	AL OCCUPATION	16h KIND OF BU	SINESS/INDUSTRY	MITCE				
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5+)	(Give kind of work of life. Do NOT use reti	lone during most of working	Total Killio OV BO	SINESS/INDUSTRY					
립	10	N/A	Superv	sor		Machine	Products				
O	17. FATHER'S NAME (First, Middle, Last)		ooper v.	The second secon	AME (First, Middle, Maiden		FIUUUUUUS				
	John Calvert O'C	Connor			Antoinette		2110				
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street and Number or Rural	Route Number, City or Tow	7. State. Zio Code)	508				
은	Carolyn O'Connor		6544 Mc	ontgomery Road	. Flkridge	Md 2	1227				
- 1	20s. METHOD OF DISPOSITION	20b. PL	ACE AND DATE OF DI	SPOSITION (Name of	DATE 20c. LO	CATION — City or T					
	1 X Buriel 2 Cremetion 3 Remova 4 Donation 5 Other Specify	Trom State cemete.	ry, cremetory or other p	Memorial Park	3/11 El						
	21. SIGNATURE OF PUNERAL SERVICE LICENS			22. NAME AND ADDRESS OF FA	ACILITY						
	· 6/0000	Loude	ren	Gary L. Kaufm	an Funeral	Home of	Elk., Inc.				
	23. PART i. Enter the diseases, or com	polications that caused the	e deeth. Do not e	5695 Main St.	, Elkridge	, Md. 2					
	ahock, or heart fellure. List	t only one ceuse on each	ine.	mo the mode of dying, edc	on as cerolec or reap	ratory arrest,	Approximate interval Between				
	iMMEDIATE CAUSE (Finel disease or condition	Ca 0 -	Min	llegue			Onest and Death				
	resulting in death)	DUE TO (OR AS A CO	ONSEQUENCE OF:	X 9 -							
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CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A CO	INSEQUENCE OF):		-						
§	cause. Enter UNDERLYING CAUSE (Disease or Injury										
띨	that initiated events	DUE TO (OR AS A CO	INSEQUENCE OF):	·							
	resulting in death) LAST										
- 1	PART II. Other significant conditions c	ontributing to death but	not resulting in th	tinderlying cettee given in	Part i. 24s. WAS AN	AUTODOV Tou	. WERE AUTOPSY FINDINGS				
CAL				o underlying coose given in	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE				
					1 YES 2	(1) NO	OF DEATH?				
Σ	DID TOBACCO USE CONTRIB	LITE TO CALIEF OF	DEATH VEC F	TAIO TO UNICEDEAL			1 YES 2 NO				
AN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (C)		иПТ						
딣	EXAMINET? H	OSPITAL:	ОТ	HER:							
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	Nursing Home 5 Desidence	6 ☐ Other (Specify) 26d. DE\$CRIBE HOW II	Males Coordings					
- 4	1 Nettiral 5 Pending	(Month, Day, Year)	INJURY	WORK?	200. DESCRIBE HOW I	NJUHY OCCURED					
BÁ	2 Accident Investigation 3 Suicide & Could get be	28e. PLACE OF INJURY —	At home, term, street,		281. LOCATION (Street of	and Number or Burel	Smuta Number				
ů	4 Homicide 6 Could not be	building, etc. (Specify)		,,	City or Town, Stete)	THE THEIR OF THE EAT	noute Number,				
COMPLETED	296. CERTIFIER 1 CERTIFYING PHYSICIAL	U. To the best of an inches	- and the second								
₽	(Uneck only			he time, date end place, end due my opinion, death occured at the			CONTRACTOR OF				
႘ႃ			and arresingation, in	my opinion, death occurs at the	time, date end prace, en	d due to the cause(e) end menner es stated.				
	29b. SIGNATURE AND TITLE OF CEIDY ILII	00.1	-	29c, LICENSE NUI		29d. DATE SIGNED	(Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMBI ETED ONLINE CO. TO.	(1701) (17)	1723	580	39	195				
	2 1/ 1/ A DUNESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH		0.	M = 5						
	31. DATE FILED (Month, Day, Year)	AVE. SU	ITE 201	BALTO.	ND 2199	7					
- 1		TEGISTHAH'S SIGNATU	ME								
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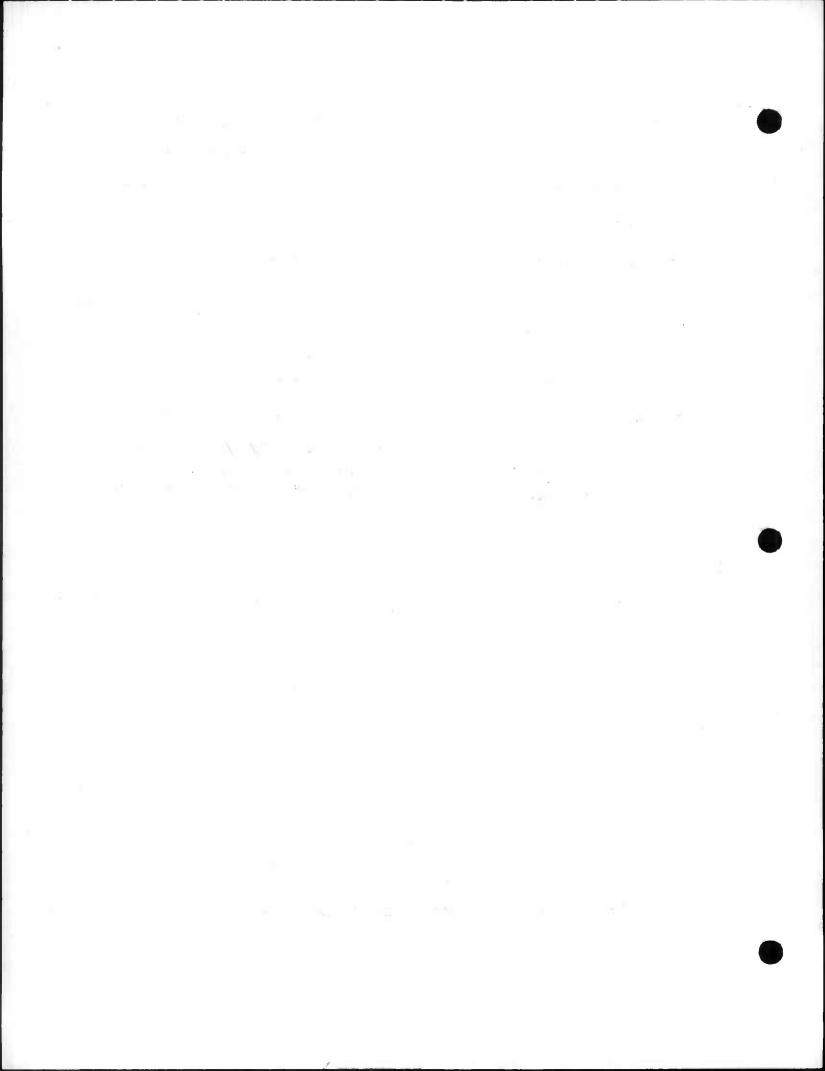
FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE CERTIFICATE OF DEATH REG. NO.												
11 5	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH 3. TIME OF DEATN										
3	JULIA	ANTHONY POLEMIS MARCH 9, 1995							YEAR	6.15 PH W			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. DATE O	F BIRTN		8. BIRTHE	LACE (State or Foreign
	217-64-1311	1 🗆 M 2 🔀 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	AUGUST 12,1912			2	GREECE
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0	205 E. JOPPA ROAD	UNIT 204	1		TOW	VSON					BA	LTIMO	RE
E C	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c, CIT	Y, TOWN C	OR LOCAT	ION						10d. INSIDE CITY
DIRECTOR	MARYLAND BALT	IMORE			rows		1000						LIMITS?
7	10e. STREET AND NUMBER				_	101	ZIP CODE	E			10g, CIT		HAT COUNTRY?
ER/	205 E. JOPPA ROAD	UNIT 20	4				21:	286					SA
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	MED	13.	WAS DEC	ENDENT O	F NISPAN	IIC ORIGIN?	(Specify Yes	or No	14. RACE	- American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WA	R OR DATES	Ю			ectly Cuba 2 ⁽¹⁾ NO	n, Maxicar Specily	n, Puarto Rio	can, etc.)		Black, Specify	White, etc.
													WHITE
里	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Gr	ve kind of	Work done	during mo	N st of workin	g	16b, F	UND OF BUS	SINESS/INI	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	Web.	Do NOT us	MEMAK	(ER					AT H	OME	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			110.			16 MOTA	IFD'S MAS	ME (Elm) 16	ddle, Maiden			
	JAMES J. LAMBROS							OLA	ME (FIRST, MIC	odie, Maiden	Sumame)	PERT	ESSIS
BE	19a. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS	(Street a	nd Number	or Rural R	Cute Number	r, City or Tow	n Stein 76	(n Corde)	
2	JOHN J. LAMBROS									MD.			
	20a, METHOD OF DISPOSITION 1 A Burial 2 Cremation 3 Ramo		20b. PLACEA						DATE	20c. LO	CATION —	City or Tow	rn, Stata
	4 Donation 5 Other (Specify)	IVEI ITOM STATE	GREEK	"ORT	HODO	K CE	Μ.	3,	/13/9	5 BAL	TIMO	RE, M	D.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF EACH ITY. RUCK TOWSON FUNERAL HOME INC.												
	* Michael &	Burk			10	050	YORK	ROAI	D TOW	SON,	MD.	21204	
	23. PART I. Enter the diseases/or c	ompilcetione that	coused the dec	ath. Do r	not enter	the mo	de of dyi	ng, auch	n aa cardle	c or reepi	ratory ar	reet,	Approximate
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	disease or condition resulting in death)	Ob	47						. 0	<i>j</i> :			
		DIME TO LO	R AS A CONSEQ	UENCE O	F):	11 1	7	14	2/				1
NO	Sequentially list conditions, Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF):												
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임	CAUSE (Disease or injury that initiated events	DUE TO (C	R AS A CONSEO	UENCE O	D: /			-101	.0				
E	resulting in death) LAST				-								į
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EDIC					_				— ¹	YES 2	d'in		COMPLETION OF CAUSE OF DEATH?
Σ	DID TOP ACCOUNT	IDITE TO CALL	CE OF DE 11			🗀						1	T YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IROLE IO CAO			H (Check o		UNC	ERTAIN	1 1				
[일	EXAMINER?	HOSPITAL:			OTHER	t:	11 - 05	100	1.00				
¥	27. MANNER OF DEATH	28a. DATE OF IN		28b. TIM		28c. INJU			6 Other (Specify) RIBE NOW II	HILIBY OO	CUBED	
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BY BY	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF	NJURY — At hon	ne, farm, i	street, facto				26f. LOCAT	ION (Street a	nd Number	r or Rural Ro	ute Number.
COMPLETED	4 Nomicide detarmined	building, at	c. (Specify)						City or	Town, State)			or twee
2	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of m	y knowledge, des	th occurr	d at the ti	me data	and place	and due !	to the cause	(a) and man	nor on stat	and .	
N N													and manner as stated.
	29b. SIGNATURE AND THE OF CHATTEER		al	1				NSE-NUM	BER				Month, Day, Year)
BE C	(KUM) INQU	LILL	0	_		- 1	D -	u	0170	0	1	3/10	115
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH STEM	27) (Type,	Print)							1	
	DR. JOSE A. HERNA	ANDEZ 756	5 OSLER	DRI	VE SI	UITE	509	TOW	SON,	MD.			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR			_								
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the huneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		TIEGIOTTI III				- VL		CAIL		DEATH	REG. NO			
	1	1. DECEDENT'S NAME (First, Middle, Last) AURELLIA PANDZIK 2. Date of Death Month Day North Day North Day North Month St. 1995 8:20 P. M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vir. local biotherm) IE INDER 1 VERD 1. V												
	- °	4. SOCIAL SECURITY NUMBER							MARCH	95	8:20 P. M			
		4. SOCIAL SECURITY NUMBER 5. SEX 1 M			8. AGE (In)		VRS.	MONTHS D	EAR AYS	HOURS MIN.	(Month, Day, Year)		Gountry	
	1	9a. FACILITY NAME (If not in		- 21	/	9		9b. CITY. TO	WN C	OR LOCATION OF DE	AUG. 16, 19		TEN!	NESSEE
	CTOR	3700 GREENVALE ROAD BALTIMORE BALTIMORE CITY												
	ည	10a, STATE	10b. COUNTY	,			10a CITI	, TOWH OR I	0017	7011				
	DIRE	MARYLAND	CITY			ALTIMO					10d. INSIDE CITY LIMITS? 14 YES 2 NO			
	RAL	100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WI 21229 U.S.A.												
	FUNER	11. MARITAL STATUS	ALE RU		T F1/F0 11 11									
		11. MARITAL STATUS 1 Never Married 2 Married IF YES, GIVE WAR				YES 2 NO If yes, specify C			ecify Cuban, Maxica	IIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No-	Black	— American Indian, White, atc.	
	ВУ	3 X Widowed 4 Divo	proed	W 123, GIVE V	WIN ON DATE				TES	2 X NO Specify	e.	Specif	WHITE	
	ETED	(Specify only	EDENT'S EDU		10	(G/ve	kind of w	USUAL OCCU	PATIO	ON st of working	16b. KIND OF BU	DUSTRY		
	PLE	8TH GRADE	0-12)	College (1-4 or 5	+)	Me. L	HOM	e refired.) EMAKET	?		н	ER HO	ME.	
once.	COMPL	17. FATNER'S NAME (First, M	liddle, Last)							18. MOTNER'S NA	ME (First, Middle, Maiden			
7	BE C	JOSEPH COGD								MARGAR	ET ANN SHE	TLEY		
be notified	TO B	MR. EARL SI				19b. 2	MAILING 750	ADDRESS (SI	FI	nd Number or Rurel F ELD ROAD	Houte Number, City or Tow — BALTIMO	n. State, Zip	Code) MD	21222
medical examiner must b		20a. METNOD OF DISPOSITION 1 Notice 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify)												vn, State
niner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
al exar		HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229												
dica		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate												
		IMMEDIATE CAUSE (Fir		11 to	-1	7-	- 1/	0.1	0 4	100	0			Onset and Death
event, the		IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Meterstelie Vulvar Carcina 37ean												
atic even	_	DUE TO (OR AS A CONSEDUENCE DF):												
BE	è l	Sequentially list conditions, If any, leading to immediate b												
er trai	ICA	cause. Enter UNDERLYING CAUSE (Disease or Injury												
or other	CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST												
		d												
any injury,	EDICAL	PERFORMED? AM.											WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
2 2											1 □ YES 2	CHO		OF DEATH?
shor	Ξ.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												1 TYES 2 NO
Item 23	IAN	25. WAS CASE REFERRED TO EXAMINER?						H (Check only		ONCERIAI				
or Item	PHYSICIAN	1 YES 2 DIO		HOSPITAL:	ER/Outpatk	ent 3 🗆	DOA	OTHER: 4 - Nursing	Nome	5 Mealdenca	8 Other (Specify)			
marked,	ВУ РН		Pending Investigation	28a. DATE OF (Month, De	INJURY ay, Year)		28b. TIME INJU	JRY	WOR	URY AT RK? 'ES 2 NO	28d. DESCRIBE HOW I	JURY OC	CURED	
28 ls	ETED E	3 Suicide 6	Could not be determined	28a. PLACE O building,	F INJURY — atc. (Specify)	At home	e, ferm, s	reet, factory,	office		26t. LOCATION (Street a City or Town, State)	nd Number	or Rural Ro	oute Number,
Item I	J.E	29a. CERTIFIER (Check only	TFYING PNYSH	CIAN: To the best of	my knowlede	ge, dest	h occurre	d at the time.	data	and place, and due	to the cause(a) and man	nor so stat	led	
2 =	COMPL	one) 2 MEDI	ICAL EXAMINE	R: On the beals of a							time, date and place, an			and manner as stated.
IMPORTANT:	TO BE	29b GRATURE AND TITLE	OF CERTIFIER	Acte	indi	P	De	tr		Dalle	98 49	29d. DAT	- 6	(Month, Day, Year)
1	F	30. NAME AND ADDRESS OF	AC- A	COMPLETED CAUS	SE OF DEATH	(ITEM:	27) (Type,	Print)	ÜΥ	GLR	NRURVI	2 (0)	61 .	
V		31. DATE FILED MARE T	4 1995	Jain a	B'S STONATI	Ran	leth							

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	REGISTRAN				CENT	FICAL	LOI	DEA	I ITI		REG. NO.				
	1. DECEDENT'S NAME (First	4.4	Powell							2. DATE O	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUME	rrs. last birthde	birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					March 9 95							
	218 01 98	YRS	MONTHS	ONTHS DAYS HOURS MIN. (Month, Day, Ypar)						Country	8. BIRTHPLACE (State or Foreign Country) BALTIMORE				
~	90. FACILITY NAME (If not in	9b. CI		OR LOCATI		ATH	1		INTY OF O						
DIRECTOR	CATON MANOR		BA	LTIMO	RE			BAI	TIMO	RE CITY					
Ä	10e. STATE	10b. COUNTY			10c.	CITY, TOWN	OR LOCA	TION						10d. INSIDE CITY	
	MARYLAND	BA	LTIMORE			AR	BUTU	S						1 YES 2 NO	
¥	100. STREET AND NUMBER	4 *********					10	f. ZIP COD				10g. CIT		HAT COUNTRY?	
FUNERAL	1313 POPLAR	AVENU.							1227			.A.			
BY FU	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Olvo		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES :	2 X NO	13	It yes, sp	CENDENT Concepts of the content of t	n, Mexicar	IIC ORIGIN? n, Puerto Ric	Specify Yes en, etc.)	or No-	Black	14. RACE — American Indian, Black, White, etc. Specify:	
	15. DEC	EDENT'S EDUC	ATION	16	ia. DECEDENT	'S LISUAL	OCCUPATI	ON		145 K	IND OF BUS	NEOC/IN	DUCTOV	WHITE	
E	(Specify only Elementary/Secondary (0	y highest grade o	completed) College (1-4 or 5 +		(Give kind	of work done use retired.	during me	ost of working	ng	100. K	INO OF BUS	SINC33/INI	DUSTRY		
MPL	7TH GRADE				HOME	MAKE	2				HC)MEMA	KING		
COMPLETED	17. FATHER'S NAME (First, M		~~~					18. MOTI		ME (First, Mic					
BE	WILLIAM F.		CHER							MAUDE		UNKN			
5	JAMES W. PO									- BA				21228	
	20s. METHOD OF DISPOSITION 1. Burlel 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetary, cremetary, cremetary, or other place) Complete Company of the place of Cemetary of Cemetary of Cemetary of Cemetary of Cemetary of Cemetary of Cemetary of Cemetary of Cemetary of Cemetary o											LOCATION — City or Town, State ALTIMORE			
	21. SIGNATURE OF FUNERAL	L SERVICE LICE	Notes		,	HI	JBBAI	NO ADDRES	NERA	L HOM	E, IN	IC.			
-	23 PART I Enter the di	ien	- www	man	- d					VENUE				D 21229	
	IMMEDIATE CAUSE (Fin	eart falluge. L	ist only one caus	se on each	ilne.	not ente	er tha mo	ode of dyl	ing, such	ss cerdia	c or respi	ratory ar	rest,	Approximate Interval Between Onset and Death	
	disesse or condition resulting in death)	→ .	OUE TO	OR AS A CO	ALLEN I	a tory	/ /	three	+					Smm.	
NO	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Corney Arky Duese 304/5												30415		
CERTIFICATION	If sny, leading to immed cause. Enter UNDERLY	NG				0. 7.								j	
Ē	CAUSE (Disease or inju that initiated events		OUE TO (OR AS A CO	NSEQUENCE	OF):									
EBI	resulting in death) LAS	d.													
	PART ii. Other significs	nt conditions	contributing to	daath but i	not rasuitin	g in the u	nderiyin	g cause c	alven in f	Part i. 2	la. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS	
EDICAL	Alzheme							PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
Σ										_				1 TES 2 NO	
N.	DID TOBACCO U		IBUTE TO CAI					UNC	ERTAIN						
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		PLACE OF O	OTHE									
14S	1 YES 2 NOT		1 Inpetient 2 26s, DATE OF			4 □ Me			sidence (6 Other (S					
BY PI	1 Nettiral 5	Pending Investigation	(Month, Da	y, Year)	-	NJURY M	1 🗆] NO	28d. OEŞCF	IBE HOW IN	IJURY OC	CURED		
	3 Suicide 6 6	, street, ta	street, tactory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							oute Number,					
COMPLETED			IAN: To the best of ex											end menner ex stated.	
	29b. SIGNATURE AND TITLE		2		0				NSE NUM		u piaca, aik			(Month, Day, Year)	
TO BE	30. NAME AND ADDRESS OF	/anles	- hu	/	Cen			Ĺ) 17	821		>	3/9	195	
	WARRE	v h	1. Ross	, m.	D. 4	1861	Dors	ey M	bell	Ome		E		40 21042	
	MAR 1 4 19	95	32. RAGISTHAF	S SIGNATU	الملا .										

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

MICHAEL

31. DATE FMARTI Day 4 995

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.											
1. DECEDENT'S NAME (First	Middle, Last)	, DOF		LIZABE		2. DATE OF DEATH		3. TIME OF DEATH			
2000	thy E	10010				MONTH 3	1 95	S 9:40 PM			
4. SOCIAL SECURITY HUME			(In yrs. last birthday	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)	APRI,	BIRTHPLACE (State or Foreign Country)			
152-16-		1 - M 2 XF	YRS.	1010.50	9 1003911 1123	04 /25	23	Maryland			
9a. FACILITY HAME (If not in	stitution, give stre	et and number)		1	N OR LOCATION OF D	EATH	9c. COUHTY	OF DEATH			
RESIDENCE OF DEC	OS PI TA	-		DA!	imore		N/A				
10a. STATE	10b. COUNTY	/-	10c. C	ITY, TOWN OR LO				10d. IHSIOE CITY LIMITS?			
MD	N,	/A		Baltimo	re		1				
10e. STREET AND NUMBER					10f. ZIP CODE		10g. CITIZEN OF WHAT COUHTRY?				
124 W. Fran		treet Apt.			21202		U.S				
1 Never Married 2		FORCES? 1 YES	2 NO	If yes	specify Cuban, Mexico		a or No- 14	. RACE — American Indian, Black, Whita, atc.			
3 Widowed 4 Divo	rced	IF TES, GIVE WAR ON D	AIES	10	YES 2 HO Specif	ly:		Specify: BLACK			
	EDENT'S EDUCA		(Give kind o	'S USUAL OCCUP	ATION most of working	16b, KIND OF BU	SIHESS/INDUS				
Elementary/Secondary (0		College (1-4 or 5+)	life. Do NOT	use retired.)	-	Baltim		City			
12th		N/A	Heal	th Aide	· ·	Health	Depar				
Booker T. C						ME (First, Middle, Malden	Surname)				
19a. IHFORMANT'S HAME (7			19h MAII II-	IC ADDRESS /Str		S Dorsey Route Number, City or Tow	o State 7to Co				
Patricia Ch								25			
20a. METHOD OF DISPOSITION 20b. PLACE AHODATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State											
20a. METHOD OF DISPOSITION \$\frac{1}{2}\$ Burlel 2 \(\triangle \t											
21. SIGHATURE OF FUHERAL SERVICE LICEHSEE 22. HAME AND ADDRESS OF FACILITY											
March Funeral Home East											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line.											
ahock, or hi	aart fallure. Lis	st only one cause on a	ach lina.					Interval Batween Onset and Death			
disease or condition resulting in death)	→ .	He pati	c Fai	ure							
, , , , , , , , , , , , , , , , , , , ,	4.	A									
Sequentially list conditi	ona. b.	OUE TO (OR AS	ary H	ypert	Tension						
If any, leading to immed cause. Enter UNDERLYI	diata	OUE TO (OR AS A	CONSEQUENCE	OF)!	Failure	2					
CAUSE (Disease or inju		DUE TO (OR AS A	COHSEQUENCE	CEGIT	1 0,1000						
resulting in death) LAS	Т							į į			
BART II Other election	- andition										
PART II. Other significa	tit conditions	contributing to death b	out not resulting	In the underly	/ing cause givan in	PERFOR	RMEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
						1 TYES 2	NO	OF DEATH?			
DID TORACCO II	SE CONTRI	BUTE TO CAUSE O	E DEATH V	ES D NO	UNCERTAI	u ka		1 TYES 2 HO			
25. WAS CASE REFERRED TO			26. PLACE OF DE			NAI					
EXAMIHER? 1 YES 2 NO		HOSPITAL:	etlent 3 DOA	OTHER:	Iome 5 - Rasidence	6 Other (Specify)					
27, MAHNER OF DEATH		28e. DATE OF IHJURY	28b. TI	ME OF 26c.	INJURY AT	26d. DESCRIBE HOW I	NJURY OCCUR	ED			
	Pending Investigation	(Month, Day, Year)	"		WORK?						
3 Suicide 6	Could not be	28a. PLACE OF IHJURY building, etc. (Spec	- Al home, larm	, street, lactory, o	ffice	261. LOCATIOH (Street a City or Town, State)	and Number or i	Rural Route Number,			
	Setermined					13111, 21010)					
		AH: To the beet of my know									
one) 2 MEOI	CAL EXAMINER:	On the basis of examination	n and/or investigat	ion, in my opinion	n, death occured at the	time, data and place, en	d dua to the co	euse(a) end menner ea atated.			
295 SIGNATURE AND TITLE	OF CERTIFIER	1-0/-	D.		29c. LICEHSE HUI	MBER	29d. DATE SI	IGNED (Month, Day, Year)			
30 HAME AND ADDRESS OF	PERCON WILL	10000000	ge 1	W)	11) 02	153	P 3	3/11/95			

22 S

AND REGISTRARY SIGNAPHE

WOODBRIDGE

GRIENE

51.

BALTIMORE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AN CERTIFICATE OF DEATH	D MEN	HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Lest)		DATE OF DEATN		3. TIME OF DEATH				
1	Roy Frank Peters Jr.		lar 11	1995 YEAR	8.14 PM				
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HR	DATE OF BIRTH Month, Day, Year)	6. BIRT	HPLACE (State or Foreign					
Ŋ	577 16 3855 1 🖫 2 🗆 F 75 YRS. MONTHS DAYS HOURS MIN				V.C.				
	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF			9c. COUNTY OF	DEATH				
DIRECTOR	Laurel Regional Hospital Laurel		Prince Georg						
REC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?					
	Md Anne Arundel Mayo	_		1 TES TO NO					
₹.	104. STREET AND NUMBER 107. ZIP CODE 21106			10g. CITIZEN OF	WNAT COUNTRY?				
FUNERAL	1.0. Box 47 3730 1cm 1100.				USA				
교	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF NIS 1 □ Never Merried 12. WAS DECEDENT OF NIS 11 □ Never Merried 13. WAS DECEDENT OF NIS 11 □ Never Merried 14. WAS DECEDENT OF NIS 15. WAS DECEDENT OF NIS 16. VES 2 NIS 17. VES 2 NIS 18. VES 2 NIS 18. VES 2 NIS 18. VES 2 NIS 19. VES 2 NIS 10. VES 2 NIS 10. VES 2 NIS 10. VES 2 NIS 10. VES 2 NIS 11. VES 2 NIS 11. VES 2 NIS 12. WAS DECEDENT OF NIS 13. WAS DECEDENT OF NIS 14. VES 2 NIS 15. VES 2 NIS 16. VES 2 NIS 16. VES 2 NIS 17. VES 2 NIS 18. VES 2 NIS 19. VES 2 NIS 19. VES 2 NIS 10. VES 2 NIS	SPANIC O	RIGIN? (Specify Yes erto Rican, atc.)	or No— 14. RAC Black	CE — American Indian, ck, White, etc.				
B	3 Wildowed 4 Divorced 1 942 1945	YES 2 X X Specify: Specify: White							
8	15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION		16b. KIND OF BUS		100				
COMPLETED	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)								
MP.	12th 21/2 Contractor		Cons	truction	on				
S			irst, Middle, Maiden						
BE		_	n Virgi		ry				
2	190. INFORMANT'S NAME (Type/Print) Sharon A. Cockram 19b. MAILING ADDRESS (Street end Number or Ru 7021 Palamar per:	ural Route	Number, City or Town	n, State, Zip Code)	Md 20706				
		Tace							
	20e. METHOD OF DISPOSITION 1	1		CATION — City or T					
	4 Donetton Other (Specify) 21. SIGNATURE OF FUNERAL/SERVICE MICENSEE 22. NAME AND ADDRESS OF			itland	Md				
	Hardesty	Fu	neral H	ome, P.	A., 12				
-	Ridgely A	ve.	, Annap	olis,	Md 21401				
	 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, a ehock, or heart failure. Liet only one cause on each line. 	such aa	cardiac or respir	ratory arrest,	Approximate Interval Between				
- 1	IMMEDIATE CAUSE (Fine) disease or condition	. ^			Onset and Desth				
- 1	disease or condition resulting in death) a. (Monic resulting in death) Due TO (OR AS A CONSEQUENCE OF):								
ا ہ	Severe Chronic obstruction	-	2-0-						
ᅙᅵ	Sequentially list conditions, If eny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
8	CAUSE (Disease or injury c. diabite with comply 4	a diabete with complication							
<u> </u>	that initiated evente DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	d. prevone								
AL C	PART II. Other eignificent conditione contributing to deeth but not resulting in the underlying ceuse given	In Pert	i. 24a, WAS AN		b. WERE AUTOPSY FINDINGS				
걸	hypertures depression		1 TYES		AMAILABLE PRIOR TO COMPLETION DF CAUSE				
PHYSICIAN: MEDIC					OF DEATH?				
z I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTA	AIN [ן ב						
등	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check this one) EXAMINER? OTHER:								
Z	1 YES 2 TNO 1 Nopellent 2 ER/Outpetfent 3 DOA 4 Nursing Name 5 Residen	ice 6 🗆	Other (Specify)						
	27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK?		DESCRIBE NOW IN	JURY OCCURED					
≽	2 Accident Investigation " 1 YES 2 NO	_							
	3 Suicide 8 Could not be determined 228. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify)	281.	LOCATION (Street et City or Town, State)	nd Number or Hural	Houte Number,				
9	29e. CERTIFIER			Color-Hall					
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at				(a) and manner or stated				
- 4			and one prince, one						
₩ (]	29c. LICENSE I	P DI	9	DATE SIGNE	O (Month, Day, Year)				
2	36. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		٠	112	-(-7)				
	1-8201 lamb Paul Dring Ste 201 Low	Au	m 2	070-	7				
	31. DATE FILED (Morith, Day, Year) 32 REGISTRAR'S SIGNATURE			. ,)					
	MAR 1 4 1995 july d'involver la chall								

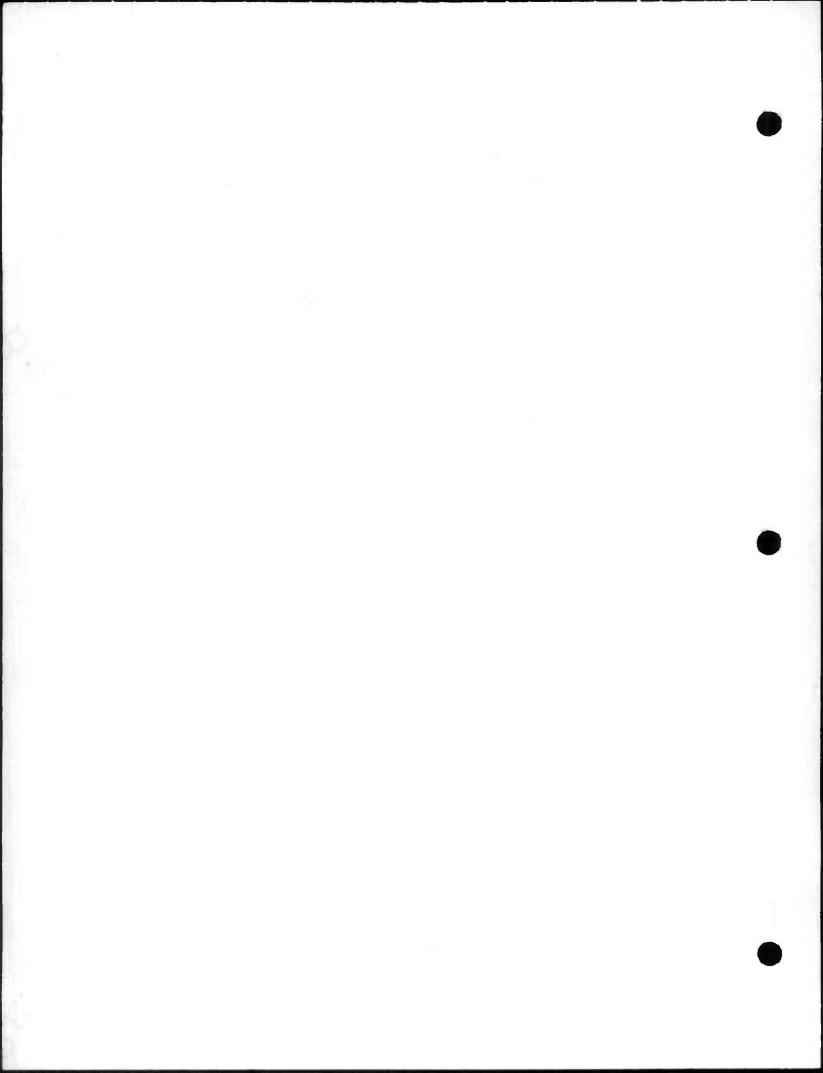
8 1

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_	TIEGIO TI D'OT				<u> </u>	111107	TIL OI	DLA	7.1	HI	EG. NO.			
	1. DECEDENT'S NAME (First,									2. DATE OF D		Y	YEAR	3. TIME OF OEATH
			LEBEL							3 - 12 -1995 5:05 A				5:05 AM
	4. SOCIAL SECURITY NUMB		5. SEX		yrs. last birth	MONT	INDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF B (Month, Day	Manel		Country	PLACE (State or Foreign
	219-54-33		1 M 2 F	9	3 YF	RS.				9-15-	-190			LAND
~	90. FACILITY NAME (If not in					9b.	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT							
5	SUMMIT NU		CATONSVILLE BALTIM						MORE					
DIRECTOR	10s. STATE 10b. COUNTY					16c. CITY, TOWN OR LOCATION						10d. INSIDE CITY		
ā	MARYLAND		CATO	NSVI	LLE						LIMITS? 1 YES 2 NO			
AL	10e. STREET AND NUMBER					10f. ZIP CODE						10g. CIT		HAT COUNTRY?
FUNERAL	98 SMITHWO	OD AV	/E			21228						U.	S.A.	
5	11. MARITAL STATUS		12. WAS OECEDEN FORCES? 1	T EVER IN U	J.S. ARMED		13. WAS OED	F HISPANI	C ORIGIN? (Sp., Puerto Rican,	ecify Yee	or No-	14. RACE	- American Indian, White, atc.	
BY	1 Never Merried 2 3 Widowed 4 Divor		IF YES, GIVE W	AR OR DATE	ES			2 NO			att.)	,		
	15. DEC	EDENT'S EDUC	CATION	1	a. DECEDE	MT'S LIGHT	AL OCCUPATION	201				INESS/IND		WHITE
COMPLETED	(Specify only Elementary/Secondary (0-	highest grade	completed) College (1-4 or 5 +		(Give kin	id of work d	lone durina mo	st of working	g	TOD, KINL	OF BUS	INESS/INL	DUSTRY	
립	12	/	Consige (1-4 b) 5 +	'	HOM	EMAK	ER			I	HOME	EMAK	ER	
Š	17. FATHER'S NAME (First, Mi	ddle, Last)						16. MOTH	ER'S NAM	E (First, Middle	Maiden S	Sumame)		
BE	LOUIS RIE	BEL J	JR.						EVA					
2	19a. INFORMANT'S NAME (7)				19b. MAI	ILING ADDI	RESS (Street a	nd Number	or Rurai Ac	oute Number, Ci	ty or Town	, State, Zip	Code)	
-	GILBERT B		ISON JR.		13	1312 MILLDAM RD. TOWS					ON,M	D.	2120	4.
	20a. METHOD OF DISPOSITI	n 3 🗆 Remo	oval from Stata			EAND DATE OF DISPOSITION (Name of PARK) RAINE PARK					DATE 20c. LOCATION — City or Town, State			
	4 Donation 5 Other	INE	E PARK 3/95 BA						ALTO.,MD.					
	N / / / /						\$ &	SON	s co) .				
William R. Pare III. HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.														
	23. PART I. Enter the dishock, or he	seasea, or coart failure. L	omplications that List only one cau	ceused ti	he deeth. I	Do not e	nter the mo	da of dyle	ng, such	ss cardiac o	or respir	atory sm	rest,	Approximats Interval Batween
	IMMEDIATE CAUSE (Final disease or condition													
ļ	resulting in death) s. Milder Longin													
_														
CERTIFICATION	Sequentially list conditions, If sny, isoding to immediate DUE TO (OR AS A CONSCOUENCE OF):											2000		
B	Sequentially list conditions, If smy, isoding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury 2015)													
Ě	that initieted events		DUE TO	OR AS A C	ONSEQUENC									2092
	resulting in death) LAST d													
- 11	PART II. Other significan	nt conditions	s contributing to	deeth but	not result	ing in the	underlying	ceuse o	iven in P	Pert I. 24s.	WAS AN	UTOPSY	24h 1	WERE AUTOPSY FINDINGS
EDICAL	Schings	ahre						,			PERFORI	AED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Seine		sorol							_ 1 -	YES 2	NO	1 '	OF DEATH?
2	DID TOBACCO US				DEATH	YES [I NO E	LINC	ERTAIN					1 PES 2 NO
Ž.	25. WAS CASE REFERRED TO						eck only one)	. 0110						
Sic	1 YES 2 NO		HOSPITAL: 1 Inpatient 2	ER/Outpati	ent 3 🗆 DC		Nursing Hom	e 5 🗆 Ras	sidenca 6	☐ Other (Spe	c(fv)			
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF (Month, De		26b.	TIME OF	28c, JNJ			28d. DESCRIB		JURY OCC	CURED	
BY		Pending nvestigation		·,. /ou//		I		ES 2	NO NO					_
- 10		Could not be	28a. PLACE Of building,	F INJURY — etc. (Specify)	At home, te	ırm, street,	factory, offic			28t. LOCATION City or Tow	(Street ar	nd Number	or Aurai Ro	ute Number,
	192344	letermined												
린			CIAN: To the best of											
COMPLETED	2 MEDIC	CAL EXAMINER	R: On the beals of ax	amination a	nd/or investi	igation, in r	my opinion, d	eath occure	ed at the ti	me, data and p	olece, and	dua to th	a cause(a)	and manner as stated.
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER	2			2		29c. LICE	NSE NUME	BER		29d. DATI	E SIGNED (Month, Day, Year)
2	Wan	1/4	kn			ho	5	111	99	71)	3-1	3-95
- 1	30. NAME AND ADDRESS OF													
	DAVID R.				205 I	EAST	DR.	ARB	UTUS	MD.				
	MAR 1 4 19	95	J. HEGISTRAI	R'S SIGNATI	UHE.									
	_ 10.	0		- Label	5.45									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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IMPORTANT: II

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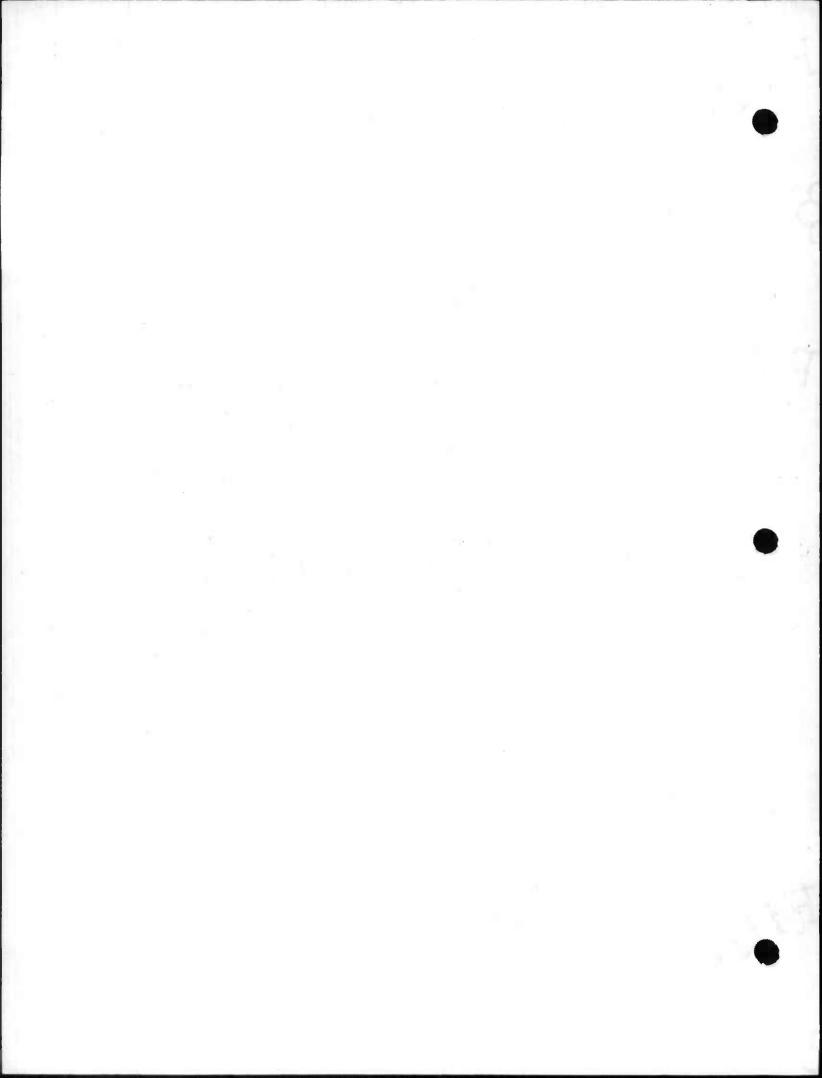
pinou

95 07667 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH HERMAN 10:02 995 March 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPI ACE (State or Formion May 1, 1921 216-14-3658 1 X M 2 - F 73 Märyland 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH Fallston General Hospital DIRECTOR Fallston Harford RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Harford Joppa 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 811 Old Joppa Road 21085 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WW II 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.}

1 YES 2 NO Specify: BY Spocky White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high entary/Secondary (0-t2) College (1-4 or 5+) 8th grade Carpenter Steel Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roemer Max Skuhr Carrie BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
811 Old Joppa Road, Joppa, MD 21085 2 (wife) Beatrice L. Roemer 20a.,METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Highview Memorial Gardens 3/13 Fallston, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock. Dr haart fallure. List only one cause Dn each lina. IMMEDIATE CAUSE (Final Onset and Death LORONARY ARTERY DISEASE disease or condition resulting in death) Our DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TYES 2 ATNO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 🗆 Nu me 5 🗆 Rasidenca 8 🗆 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural t YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as atated.

296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) vek 837 March 10, 1995 ann, ms 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IVEK 5, FALLSTON, MD21047 VARMA BELATR ROAD 2112 31. DATE FILED (Month, Dev. Year) 32 MESTRAL'S ASSAULT

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.



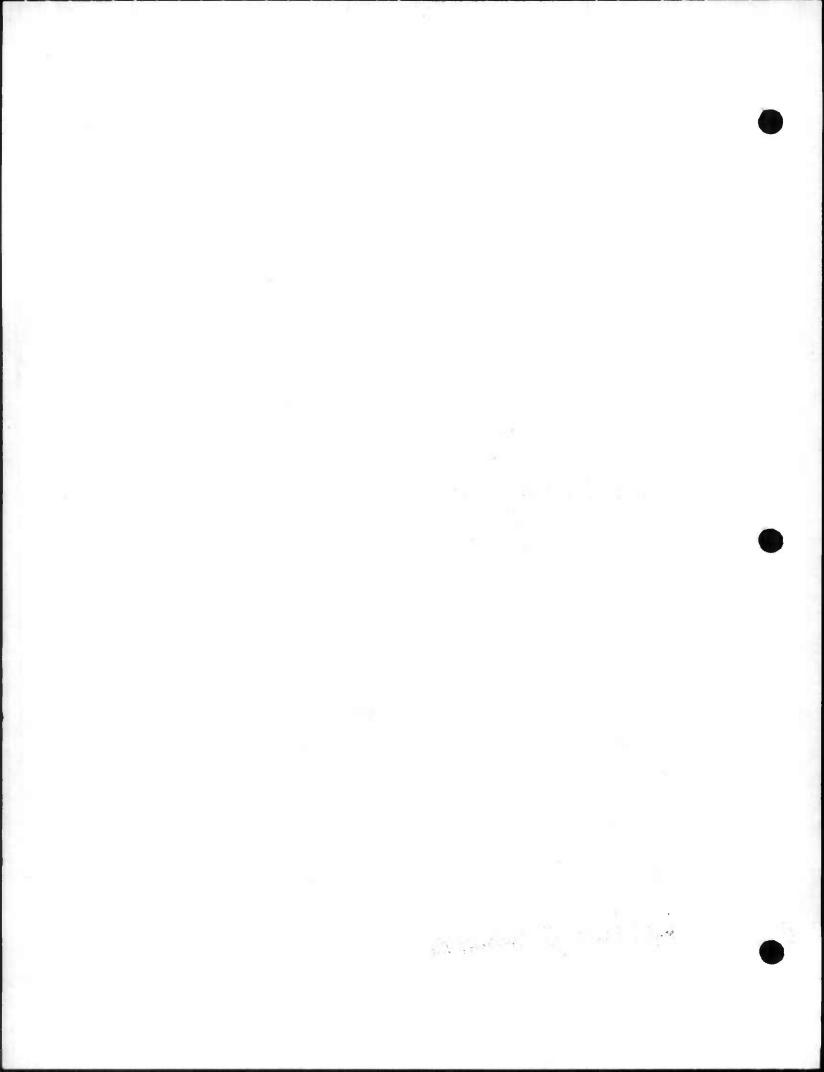
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an experiment of each. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	IEALTH AND DEATH	MENTA	L HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last) RUSSELL	WILLIAM	ROGE	RS			OF DEATH	"1995 "	3.	TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 219-71-2115	MXM2□F 36	MAX M 2 G F 36 YRS. MONTHS DAYS HOURS MIN. FEB. 8, 1959 MA							ACE (State or Foreign	
TOR	98. FACILITY NAME (If not institution, give 2244 Sidney Avenument)			96. CITY, TOWN OR LOCATION OF DEATH Baltimore						ГН	
DIRECTOR	100. STATE 100. COUNT	Y		1 timore			10d. INSIDE (VLIMITS? Y YES 2				
FUNERAL	2244 Sidney Avenu	ıe			1230			Unite	OF WHA	T COUNTRY?	
≧	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuben, Mexico 2 NO Specia	en, Puerlo f	l? (Specify Yes Rican, etc.)	or No- 14.	Black, W	American Indian, Thite, atc. White	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	JCATION s completed) College (1-4 or 5+)	16e. DECEDENT'S U (Give kind of wo life. Do NOT use FOOD Pre	ork done during mo retired.)	st of working	A.A.F.	18b. KIND OF BUSINESS/INDUSTRY				
	17. FATHER'S NAME (First, Middle, Last) Raymond	W.			18. MOTHER'S NA	Restaurant ME (First, Middle, Malden Surname)					
TO BE	19a. INFORMANT'S NAME (Type/Print)		Rogers	DORESS (Street a	Helen nd Number or Rural				Bro	wn	
	Mr. Ralph Pierpont 2244 Sidney Avenue Baltimore, MD. 21230 200, METHOD OF DISPOSITION 201, PLACE AND DATE OF DISPOSITION (Name of DATE 200, LOCATION — City or Town, States										
1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 1 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 2 (A Burlel 2 Cremetton 5 Other (Specify) 3 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 Other (Specify) 4 (A Burlel 2 Cremetton 5 O											
	► Volerie &	- Colymak		23/ Ea	st Patap	SCO P	venue	Balt	imar	e,MD.21225	
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart fellure. List only one cause on each line. Approximate interval Between Onset and Death a. Metatata Cadhocarinana of lung DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL	PART ii. Other significant condition	ns contributing to desth b	out not resulting in	the underlying	cause given in	Part I.	24a. WAS AN PERFOR	MED?	CO OF	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH?	
AN: A	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE C	PEATH YES		UNCERTAI	N 🗆			- 1	YES 2 NO	
YSICI	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out		OTHER:	a 5 D Residence	6 🗆 Other	r (Specify)				
> II	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	286. TIME INJUI	RY WO	URY AT RK? 'ES 2 NO	28d. OE\$	CRIBE HOW II	NJURY OCCUR	D		
TED B	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	/ — At home, farm, str cify)	ome, farm, street, factory, office			261. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)				
COMPLE		ICIAN: To the best of my know ER: On the besis of examination							use(a) an	d menner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	ma ma			29c. LICENSE NUI				ENED (Mo	onth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, F		1122/8	4		Mar	ch 13, 1995		
	31, DATE FILED (Month, Day, Year) MAR 1 4 1995 A	31. REGISTRAR'S SIGN	ATURE	osp. tal	Cente	-		. —			
- 1	MAK 1 4 1995 %	UN ATTENDED	64							i	

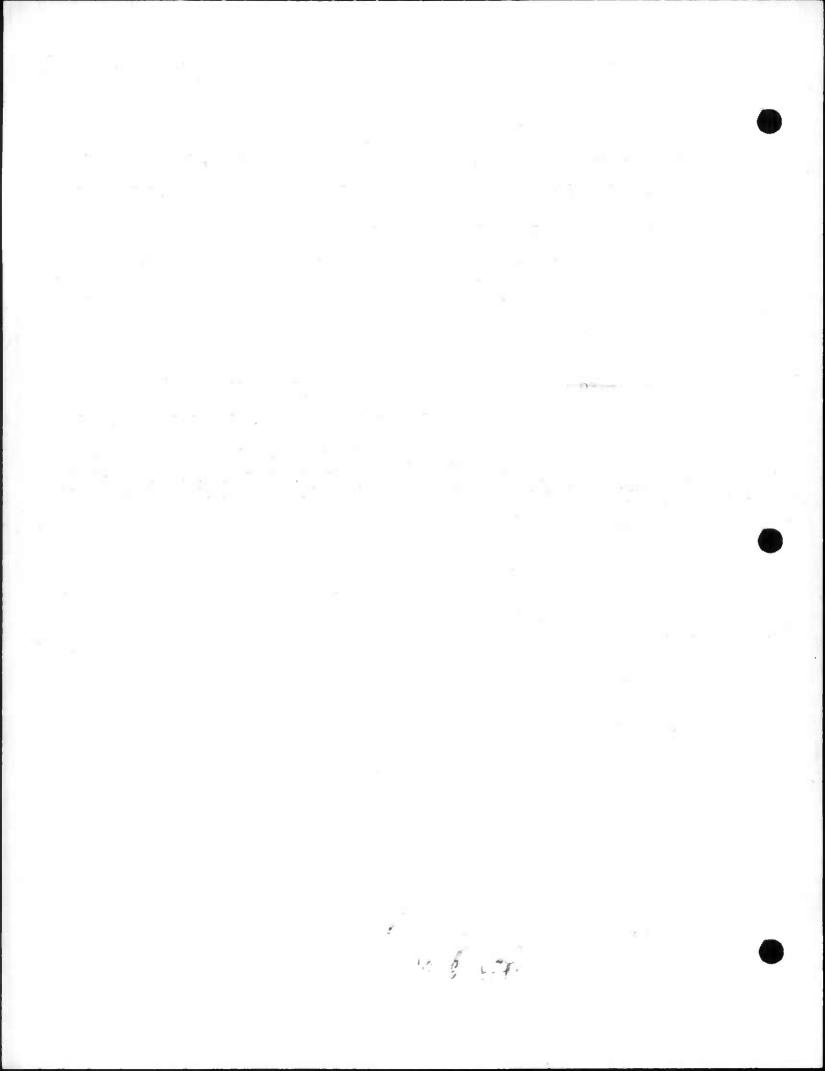


DIVISION OF VITAL RECORDS, P.O. BOX 68760

9.5	er this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ath with the State Dept. or Health and Mental Hyglene prior to burial, cremation, or removal.	anarked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
SICIAN: The	certificate h	1, or item
9.5	THE FUNERAL DIRECTOR: After this lifed within 72 hours after death with	is marke
OSPITAL DR ATTENDIN	NIRECTOR	ORTANT: if item 28
PITAL D	ERAL D	T: If Ite
TO THE HOS	TO THE FUNERAL DIRECTOR: After to be filed within 72 hours after death	IMPORTAN
-		-

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG	. NO.					
	1. DECEDENT'S NAME (First, Middle, Leat)	T1-000 T F	20222	0.17		2. DATE OF DEA			3. TIME OF DEATH			
3	Jettre Rohi	JETTIE NSO	ROBERS	ON		MONTH 3	BAY	95 MEAR	1032 R.M			
1	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	RE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HR					HPLACE (State or Foreign			
- 1	718- 09- 9303	1 € M 2 □ F	68 YRS.	MONTHS DAYS	HOURS MM.	7. DATE OF BIRT (Month, Day, W MAY 14,	ear)	SC	try)			
-	9a. FACILITY NAME (If not institution, give s		1	OR LOCATION OF D	EATH	9c. CO	UNTY OF I	DEATH				
DIRECTOR	BAYVIEW MEDICAL CENTER BALTIMORE BALTIMORE CITY RESIDENCE OF DECEMENT BALTIMORE CITY											
3	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE C											
		TIMORE CITY	TIMORE				LIMITS XX YES					
M	10e. STREET AND NUMBER			10	f. ZIP CODE		10g. CI	TIZEN OF	WHAT COUNTRY?			
ш	2000 ODELL AVENUE	APT. 316		2	1237		UNI	TED ;	STATES			
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 7	ES 2, NO	If yes, sp	CENDENT OF HISPA	fy Yes or No-	14. RAC	E — American Indian, k, White, elc.				
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATESLA.	1 TYES	2/QNO Specif	ly:		Spec	BLACK			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	(Give kind of a	USUAL OCCUPATI	ON ost of working	16b. KIND C							
PLE	Elementary/Secondary (0-12)	LABOF				BRARY						
MO	17. FATHER'S NAME (First, Middle, Last)		<u> HADOI</u>	LIST	16. MOTHER'S NA							
BE C	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) 17. FATHER'S NAME (First, Middle, Meiden Surname) 18. MOTHER'S NAME (First, Middle, Meiden Surname) DICEY WELLS											
	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street	and Number or Rural		ov Town, State, 2	(ip Code)				
5	RUBY ROBERSON								D 21237			
	RUBY ROBERSON 200. ODELL AVENUE APT. 316 BALTIMORE, M 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE of DISPOSITION (Name of cemetery, cremationy or other place) 4 Donation 5 Other (Specify) 4 Donation 5 Other (Specify) 20b. PLACE AND DATE of DISPOSITION (Name of cemetery, cremationy or other place) 4 Donation 5 Other (Specify) 22 NAME AND ADDRESS OF SCHILLY.											
	4 Donation 5 Other (Specify)	The state of the s	cemetery, crematory or o	KING M	EM. PK.	3+17-95	RANDAL	LSTO	MN, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE .	/	CATAT	NO ADDRESS OF FA	CILITY T.TAMS F	S 270	प्रवच	DHILTON PASS			
	palven J. 1	Villiam	6	(Gary	P. Marc	h, F.H.)	BAL	TO	MD 21229			
	23. PART I. Enter the diseases, or o	complications that cau	and the deeth. Do r	not enter the mo	de of dying, aud	h as cardlec or	reapiratory a	rreat,	Approximete Interval Between			
	shock, or heart fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel											
	disease or condition resulting in death) a. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):											
SAT	news, resuming to intrinsicate											
Ĕ		OUE TO (OR A	S A CONSEQUENCE OF	n:	C	011-010	May .		unknown			
E	rasulting in death) LAST	d										
	PART II. Other aignificent condition	s contributing to deet	h but not resulting i	n the underlyin	a ceuee alven in	Part I. 24s. W	S AN AUTOPSY	245	WERE AUTOPSY FINDINGS			
DICAL	MAI PROLIM					PE	RFORMED?	240	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MED	Piccini					1 🔀 Y	ES 2 NO		OF DEATH?			
Ξ.	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YE	S W NO F	LINCEPTAIL				1 TYES 2 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		JUNCERIAN	, U						
Sic	EXAMINER? 1 YES 2'X NO	HOSPITAL:	Outpetient 3 DOA	OTHER:	a 5 🗆 Residence	6 (1) Other (Parell						
₹ I	27. MANNER OF DEATH	28a. DATE OF INJUI	RY 28b. TIM	E OF 28c. INJ	URY AT	28d. DESCRIBE H		CCURED				
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yes	INJ		PRK?							
	3 Suicide 6 Could not be	26a. PLACE OF INJI building, atc. (5	JRY At home, farm, s	street, factory, offic		261. LOCATION (S	treet and Numbe	or Rural I	Route Number,			
COMPLETED	4 Homicide determined					City or Town,	ordie)					
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my ki	nowladge, death occurre	ed at the lime, date	and place, and due	to the cause(a) an	d manner as sto	rted.				
O.	one) 2 MEOICAL EXAMINE	R: On the basis of examine	ntion and/or investigation	n, in my opinion, d	eath occured at the	time, data and place	a, and dua to t	lha cause(a) and mannar as stated,			
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	/BER	29d. DA	TE SIGNEO	(Month, Day, Year)			
	a Busch 1	10			95019		▶ 3	19/0				
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CAUSE OF	DEATH (ITEM 27) (Type,	Print)	Factor	Ave Rol	+ 417		3			
	Alisa B. Busch, MD			7-17970	LASTELLA	WATER DECL	و١٠,١٠٠	42	4			
	MAR 1 4 1995	Sa REGISTRAR'S S	GNATURE W DONLALL									

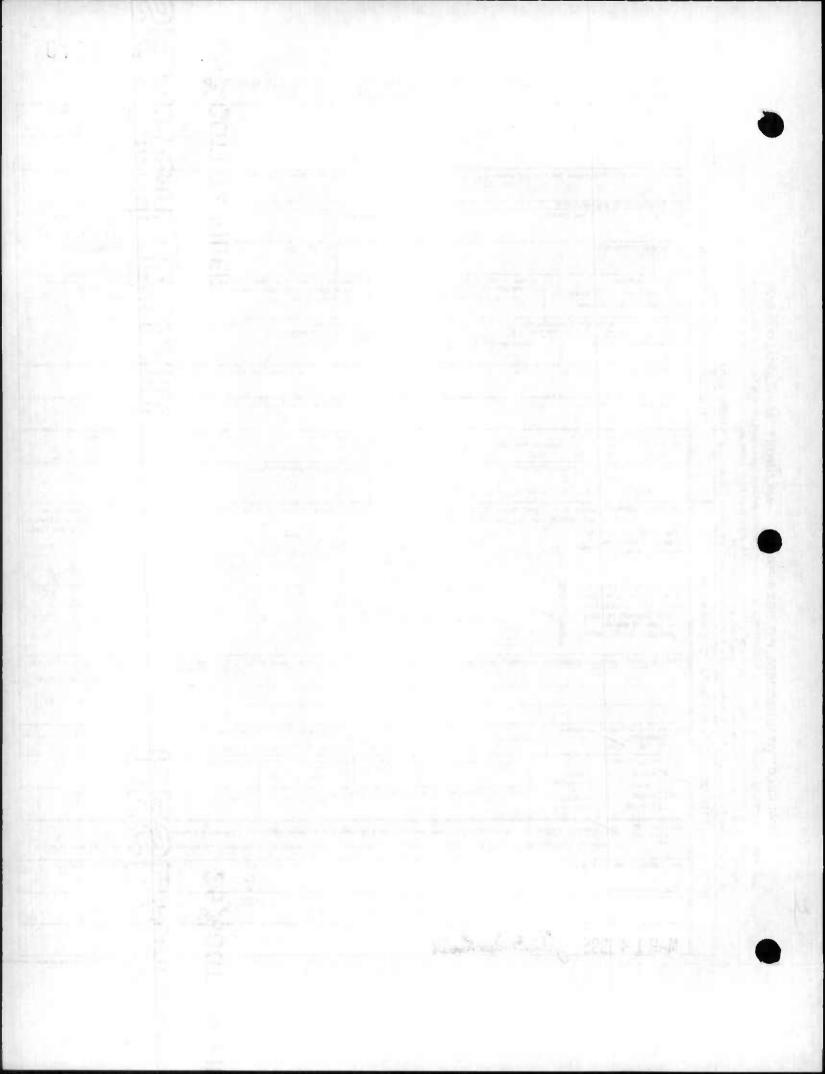


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM				GIENE G. NO.						
	1. DECEDENT'S NAME (First, Middle, Last) Josephine Stell:	a Russo				2. DATE OF DE MONTH		YEAR 95	3. TIME OF DEATH 8:25 D M				
	4. SOCIAL SECURITY NUMBER 214-74-9607			UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIT (Month, Day, Aug. 2	0,1904	8. BIRTHPLACE (State or Foreign Country) Washington, D					
POR	99. FACILITY NAME (If not Institution, give of Summit Nursing		9b.		n LOCATION OF DE			9c. COUNTY OF DEATH Baltimore					
DIRECTOR	Maryland 10b. count	Baltimore	10e. CITY, TO	OWN OR LOCAT	onsville	11.10			10d. INSIDE CITY LIMITS? 1 YES 2X NO				
FUNERAL	100. STREET AND NUMBER 40 Briarwood Ro	ad		101	21228		10g. CIT	WHAT COUNTRY?					
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPAN acity Cuben, Mexica 2 NO Specify	n, Puerto Rican,		14. RACI Black Spec	E — American Indian, k, White, etc. White				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	18e. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during mo ired.)			of Business/ini	DUSTRY					
BE COM	17. FATHER'S NAME (First, Middle, Last) Louis Cifala		nonen	area	18. MOTHER'S NA Cather		Malden Surname)						
TO E	190. INFORMANT'S NAME (Type/Print) Robert F. Russo (Son) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 11862 Ramsburg Road, Marriottsville, Maryland 21044												
	20s. METHOD OF DISPOSITION 12 Surfect 2 Cremetion 3 Removal from State 2 Cremetion 5 Other (Specify)												
	22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland												
	IMMEDIATE CAUSE (Final disease or condition	List only one cause on ea	the deeth. Do not och line.	enter the mo	da of dying, suc				Approximate Interval Between Onset and Death				
7	resulting in desth)	DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):												
MEDICAL CE	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 NO								WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (Ch	eck only one)			1 YES 2 NO				
	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpatient 2 ER/Output 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Hon 28c. IN.	e 5 Reeldence URY AT RK? /ES 2 NO		elfy) E HOW INJURY OC	CUREO					
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, ferm, stree	t, factory, offic		281. LOCATION City or Town	(Street end Numbe n, State)	r or Rural i	Route Number,				
COMPLETED	The state of the s	ER: On the best of my knowle							e) end menner se stated.				
TO BE	29b. SIGNATURE AND TITLE OF TENTIFIE	O MD. D36942 3/13/											
	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF OEA	AKHIA	11	D. 10	209, 4	reder	ich	PD 21278				
	MAR 1 4 1995 Ja	hi devilor had	4				15		DHMH-16 Rev 1/89				



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATN IDA LILLIAN SHER MAR. 9, 1995 4:15 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) B. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. 1 M 2 D YRS. 488-01-4845 SEPT.4,1911 MISSOURT Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SINAI HOSPITAL BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE TY YES 2 ND permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? furneral ornector, page 5 should be detached for use as the burial-transit 6010 CLOVER ROAD 21215 U.S.A. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND IF YES, GIVE WAR DR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC DRIGIN? (Specify Yee or No—If yes, specify Cuban, Mexicon, Puerto Rican, etc.)

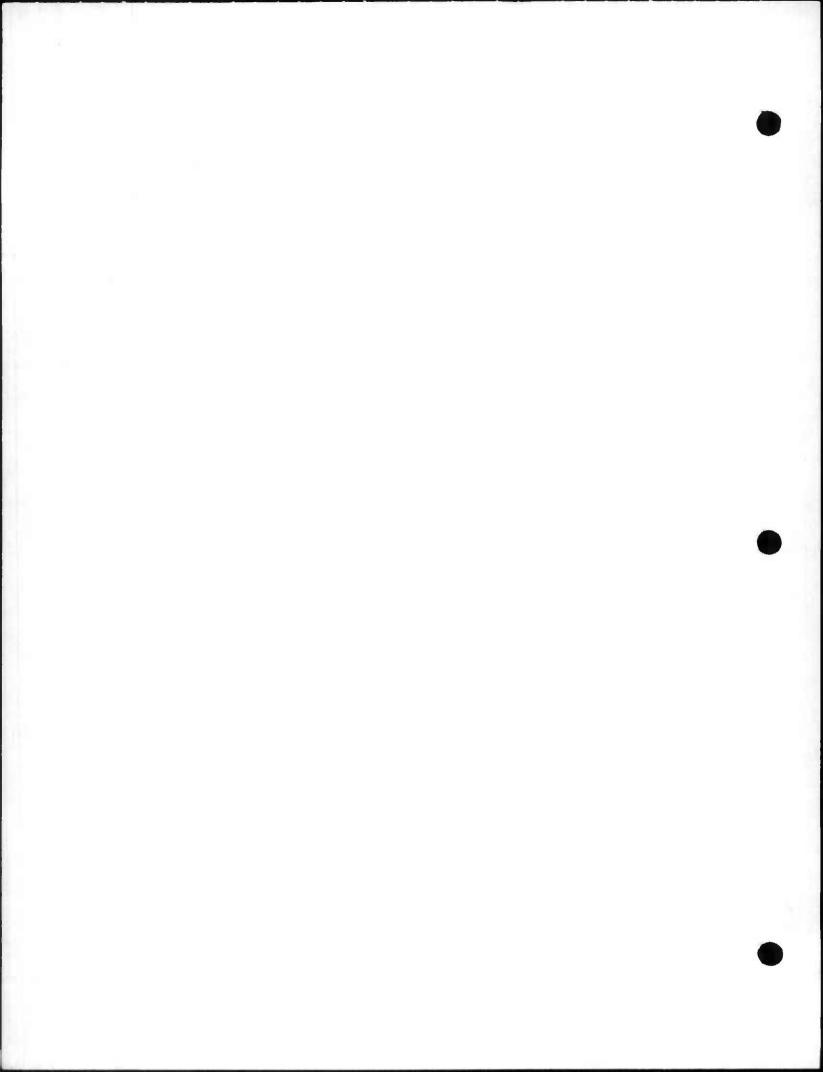
1 YES 2 NO Specify: 14. RACE --- American Indian, Black, White, etc. 1 Never Married 2 Married BΥ Specify: WHITE 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPLE 12th. ASSISTANT MANAGER DEPARTMENT STORE once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) ALBERT FRANKEL BE ANNA STEINBERG notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RABBI MARTIN E. SHER 3408 PARKINGTON AVE., BALTIMORE, MD. 21215 9 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Donation 8 - Other (Specify). GUDATH ISRAEL OF BALTO. CONG. 3/19/95 ROSEDALE, MD examiner 21. SIGNATURE OF FUNERAL SE 22. NAME AND ADDRESS OF FACILITY hours after death. SOL LEVINSON & BROS., INC. n by the f 6010 REISTERSTOWN RD , BALTO 21215 MD. medical completely filled in by rial, cremation, or remo-23. PARTA. Enter the dis ses, or come cartions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the state of disease or condition BREAST CANCER METASTATIC event, reaulting in death) 6 YRS executed within DUE TO (DR AS A CONSEDUENCE OF): in and com to burial, (traumatic CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE DF): attending physician intal Hyglene prior to if any, leading to immediate certificate be Enter UNDERLYING CAUSE (Disease or injury other DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the death been signed by the atte Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL that any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? requires Shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: has be Dept. WE 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) The The mate After this certificate death with the State HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: ' 1 TES 2 NO 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural М 1 YES 2 ND ВҮ Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 99 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after ditem 28 is COMPLETED 8 Could not be 4 Nomicide determined hours a Hem 29s. CERTIFIER

(Chart only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and menner as stated. TO THE HOSPITAL O TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If ite (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 MD 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MD SINA, HOSPITAL Of

37 REGISTRAR'S GRINTUPE

Day, Year) 4 1995

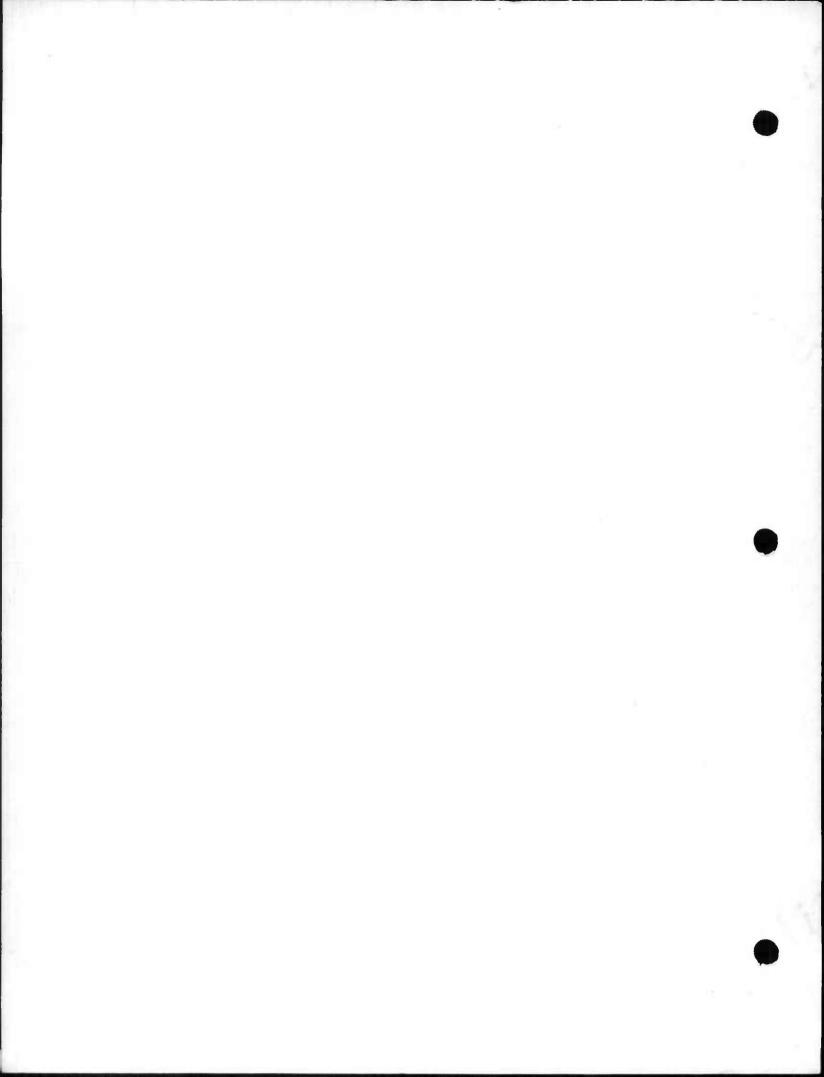
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death centificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this cenfificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR		STATE OF MARY	LAND /	DEPAR	RTMENT	OF H	EALTH AND DEATH	MENT	TAL HYGIEN				
	1. DECEDENT'S NAME (First, M	fiddle, Last)						DEATH	2. DA	TE OF DEATH			3. TIME OF DEAT	н
	Anna P. S	Schwart	Z							NTH _ D/	3	95	6:50	Ам
	4. SOCIAL SECURITY NUMBER	٦ 5.	SEX 6. AGE	(In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DA	TE OF BIRTH			IPLACE (State or Fo	
	216-03-5541 9e. FACILITY NAME (If not institu		□ M 2 💢 F	83	YRS.	MONTHS	DAYS	HOURS MIN.	SEI	onth, Day, Year) PT. 4,19		Countr	MARYLANI	
OR	Wicomico Nur		r location of d bury	EATH			COMI							
티ս	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION													
DIRECTOR	MARYLAND	WICOMI	rco		11.	LISE		ION					10d. INSIDE CITY LIMITS? 1 YES 2	
	10e. STREET AND NUMBER							ZIP CODE			10g. CIT	IZEN OF V	WHAT COUNTRY?	NO
FUNERAL	900 BOOTH STREET							21801					S.A.	
3	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR				ARMED 13. WAS DECENDENT OF HISPANIC						or No—	14. RACE	- American India	in,
BY F	1 Never Married 2 Me 3 Wildowed 4 Divorce		FORCES? 1 YES	DATES	2 MNO If yes, specify Cuban, Mexico 1 ☐ YES 2 MNO Specify					to Rican, etc.)			white, etc.	
	TA .		ON	I 40 - 55									***************************************	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)							N st of working	orking 16b. KIND OF BUSINESS/INDUSTRY					1
2	8th. College (1-4 or 5+) CLERK NEWS STAND)				
Ö	17. FATHER'S NAME (First, Middle	fle, Last)						18. MOTHER'S NA	AME (Firs			71111111		
BE	HYMAN	POI	TTS					DORA	A			UNKN	OWN	
10	19e. INFORMANT'S NAME (Type							nd Number or Rural						
-	MR. DANIEL SO						_	Y DRIVE						
	20a_METHOD OF DISPOSITION 20b_PLACE AND DATE OF DISPOSITION Name of cometery, cremetory or other piece) 20b_PLACE AND DATE OF DISPOSITION Name of cometery, cremetory or other piece) 20b_PLACE AND DATE OF DISPOSITION Name of cometery, cremetory or other piece) 20b_PLACE AND DATE OF DISPOSITION Name of cometery, cremetory or other piece) 20b_PLACE AND DATE OF TOWN, State 20b_PLACE AND DATE OF TOWN, State 20b_PLACE AND DATE OF TOWN, State 20b_PLACE AND DATE OF DISPOSITION Name of cometery, cremetory or other piece) 21c. SIGNATURE OF FUNERAL SERVICE LICENSEE													
													-	
	SOL LEVINSON & BROS., INC.													
	22 PART I Enter the dies	VV V	VI IM	ren		6	010	REISTER	STOV	N RD.,	BALTO).,MD		
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiretory errest, shock, or heart feiture. List only one cause on sech line.										Approximation Interval Ba			
	IMMEDIATE CAUSE (Finel disease or condition										Onset and	Death		
	resulting in deeth) a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):										1 Mor	th		
z												Years	,	
E	Sequentially list conditione, if any, leading to immediate Arteriosclerosis, Diffused DUE TO (OR AS A CONSEQUENCE OF):									1000	,			
2	cause. Enter UNDERLYING CAUSE (Disease or injury		Diabetes DUE TO (OR AS										Years	3
CERTIFICATION	that initieted events resulting in deeth) LAST		DOE TO (OR AS	A CONSEC	JUENCE O	+):								
		d												
¥	PART ii. Other algnificant				eeulting	In the ur	nderlying	cause given in	Pert I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FI	то
ă	Bilateral									1 - YES 2	NO X		OF DEATH?	AUSE
PHYSICIAN: MEDIC	Cancer of	the Co	lon with C	hole	ctom	У							1 TYES 2 TH	Ю
¥	25. WAS CASE REFERRED TO N	MEDICAL					26. PL	ACE OF DEATH (C)	heck only	/ one)			N/A	
SIC	EXAMINER?		OSPITAL: Inpetient 2 ER/Out	ipatient 3	□ DOA	OTHEI	₹:	5 Residence						\neg
ᅔ	27. MANNER OF DEATH		28e. DATE OF INJURY (Month, Day, Year)		28b. TIN		28c. INJU	JRY AT	T	DESCRIBE HOW I	NJURY OC	CURED		\dashv
EA	1 Natural 5 Per 2 Accident Inv	nding watigation	(monet, pay, rour)			М		ES 2 NO						
		ould not be termined	26e. PLACE OF INJUR building, etc. (Spe	Y — Af ho ecify)	me, ferm,	street, fec	ory, office		281. L	OCATION (Street (City or Town, State)	and Numbe	r or Rural F	Route Number,	
ا ت	29e. CERTIFIER 1 TY CERTIF	YING PHYSICIAN	: To the best of my kno	eledos de	eth occurr	ad at the t	Ima data	and place, and du	to the	**************************************		4.4		
COMPLETED			n the beele of exeminati										e) end menner ee st	ated.
H	296. SIGNATURE AND TITLE OF	F CERTIFIER	m 1	10)			29c. LICENSE NU					(Month, Day, Year)	_
임	30. NAME AND ADDRESS OF P	ERSON WHO CO	OMPLETED CAUSE OF D	EATH (ITE	М 27) (Туре	, Print)		D0202	6		IV1	arcn	08, 199	0
	F. G. Arthe	s, MD	1622A Oc	ean	Pine	S	Ber	lin, Md.	21	811				
	31. DATE FILED (Month, Day, Yea	er)	TE .REGISTRANS SIG	KLIE	14,									
	MAR 1 41	333												



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital on requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hyplene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

REGISTRAR			(CERTIF	CATE C	F DEATH		REG. NO.			
1. DECEDENT'S NAME (First, A	fiddle, Last)						2. DATE OF	OEATH		3. TIME OF OEATH	
HENRI	ETTA	5	SHERER				MAR.	9,199	YEAR	6:30 A	
4. SOCIAL SECURITY NUMBER	R	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER 1 YEA	AR IF UNDER 24 HRS.	7. DATE OF	BIRTH		THPLACE (State or Foreign	
065-10-6826	5 A	1 🗆 M 2X 🗆 F	89	YRS.	MONTHS DAY	YS HOURS MIN.	(Month, D	,	Cour	ntry)	
9e. FACILITY NAME (If not insti		ef and number)			9b. CITY, TOW	VN OR LOCATION OF O				POLAND	
LORIAN NURS		ME			COLUM				HOWAF		
	OK COUNTY	-		10c. CITY	Y, TOWN OR LO	CATION				10d. INSIDE CITY	
MARYLAND	HOWAI	RD		COI	LUMBIA						
100. STREET AND NUMBER 5764 STEVE	ENS FO	REST RD				21645				S.A.	
11. MARITAL STATUS 1 Never Married 2 M 3 Widowed 4 Olvoro	arried	12. WAS DECEDEN FORCES? 1 JF YES, GIVE W	YES 2X	ARMEO NO	If yes	OECENOENT OF HISPA , specify Cuben, Mexic YES 2 X NO Specif	an, Puerto Rica	Specify Yes o an, etc.)	Bia	CE — American Indian, ck, White, etc.	
15. OECEC	ENT'S EOUCA	TION	16e.	OECEOENT'S	USUAL OCCUP	ATION	16b. KJ	NO OF BUSIN	IESS/INOUSTRY		
Elementery/Secondary (0-12		College (1-4 or 5	-)	life. Do NOT us	e retired.)	most of working					
12th.	12th. HOUSEWIFE						AT HO	ME			
17. FATHER'S NAME (First, Midd	fle, Last)					16. MOTHER'S NA	AME (First, Mide	dle, Maiden Su	ımame)		
BERYL		SEN	ILOFF			RUNN	IYE		HY	ATT	
19e. INFORMANT'S NAME (Тур	e/Print)			19b. MAILING	AOORESS (Stre	eet end Number or Rural	Route Number,	City or Town,	State, Zip Code)		
MR. BRUCE SE				2793 E	RIVERS	IDE DR.,WA	NTAGH	LONG	ISLAND,	N.Y. 11793	
20e. METNOO OF OISPOSITION 1 Strip Burlel 2 Cremation 4 Donetion 6 Other (S	3 KRemov	al from State	cemetery,	crematory or of			OATE		TION — City or 1		
21. SIGNATURE OF FUNERAL !		eset ,	WELLIA	OOD C	EMETERY 22. NAME	Y ANO ACORESS OF FA	3/12/95 NCILITY	<u> </u>	ONG ISI	CAND, N.Y.	
> Court	Ma	To	11			LEVINSON 10 REISTER				/D 21215	
23. PART & Enter the dise	ases, or cor	mplications tha	t ceused the	death. Do n	ot enter the	mode of dving, suc	th es cerdier	c or reepire	tory arrest.	Approximete	
innock, or heal	rt failure. La	only one ceu	se on each ii	ne.		, , , , , , , , , , , , , , , , , , , ,			,	Interval Between Onset and Death	
disease of condition	a.		OR AS A CONS	PEOUENCE OF	3.					one ment	
	C 10	AR 44				W Disea	00				
Sequentially liet condition if any, leeding to immedia	ate II	DUE TO	OR AN A CONT	INDURNCE OF	7:	uf Dises					
ceuse. Enter UNDERLYING CAUSE (Disease or Injury		Cong	extere	Hear	+ tail	ure					
that initieted events resulting in deeth) LAST		OUE 10	(OR AS A CONS	SEQUENCE OF	3.			,			
resulting in deeth) LAST	d. ,	Mult	+ enfa	nct t	Stroke	s) De	nente	a			
PART II. Other significent	conditione	contributing to	deeth but no	t resulting i	n the wnderly	ving cause given in	Part I. 24	ia, WAS AN AL	ITOPSY 24	b. WERE AUTOPSY FINOINGS	
atour	Film	ellatu	n / (Thron	Le)			PERFORM	EO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
Colm		ancer					- '	YES 2	MO	OF CEATH?	
DID TOBACCO USI			IISE OE DE	ATL VE	s II NO	□ UNICEDTAL				1 TYES 2 MO	
25. WAS CASE REFERRED TO I		DOIL TO CA			N (Check only o		NE				
EXAMINER?	1	IOSPITAL:			OTHER:						
27. MANNER OF CEATN		26e. OATE OF	INJURY	26b. TIME		INJURY AT			URY OCCUREO		
1 Natural 5 Pe		(Month, D	my, Year)	INJ	URY	WORK?	1272	NA	U.I. OGGUNEO		
2 Sudalda	watigation	28e. PLACE O	F INJURY — At	home, ferm. a	1			* * * *	d Number or Rural	Route Number	
_ 0 _ 00	uld not be termined	building,	Mc. (Specify)	1 2 4 7			City or 1	Town, State)	or ruled		
						date end place, end due					
		On the beele of e	cemination end/c	or investigation	n, in my opinio	n, death occured at the	time, date en	d plece, end	due to the ceuse	(e) end manner es stated.	
29b. SIGNATURE AND TITLE OF	F CERTIFIER					29c. LICENSE NU	MBER		29d. OATE SIGNE	O (Month, Day, Year)	
Stoffler	Kho?					1244	185	-	Marci	49,1995	
30. NAME AND ACORESS OF P	ERSON WNO	COMPLETEO CAUS	BE OF OEATN (IT	/		0				1	
JERRY ANN 1 31. OATE FILEO (Month, Day, Yes	4 UNI	32. REGISTRA	KNOL.		RTH	COLO	LMB1	A, 1	MARYL	AND 21045	
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	ANNA		SAPPERST	ZTM						MAR 11.1	995	YEAR	1 10
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. I	st birthday)	IF UNDE	R t YEAR	IF UNDER	1 24 HRS.	MAR. 11,1	993	6. BIRTH	6:58 A M
1	098-24-3394	1	1 🗌 M 2 🖫 F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	•	Countr	γ)
	9a. FACILITY NAME (If not in		reet and number)	63		9b. CITY	MAY 26,1909 MARY						ARYT.AND
Œ	MODULTUTECO	HOODE	DAT OFFI										
읝	NORTHWEST	HUSPI'	PAL CENT	<u>sr</u>		L RA	NDAL	LSTO	WN_		BA	L.TTM	ORE
DIRECTOR	10e. STATE	10b. COUNTY	1		10c. C/1	Y, TOWN	OR LOCA	TION					10d. INSIDE CITY
5	MARYLAND	BALTIMORE						LIMITS?					
AF	10e. STREET AND NUMBER	10f. ZIP CODE						10g. CIT	IZEN OF V	VHAT COUNTRY?			
EB.	7920 SCOTTS	LEVE	ROAD		21:							U.S.	λ
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED			ENDENT C	F HISPAN	IC ORIGIN? (Specify Yes	or No-	14. BACE	- American Indian
	1 Never Merried 2 Married FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				MO			specify Cuben, Mexican, Puarto Rican, etc.) ES 2 NO Specify:				Speci	t, White, atc.
BY	3 Widowed 4 Divo	rced						X					WHITE
	15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)		ECEDENT'S	work done	during mo	ON st of working	10	16b. KIND OF BUS	INESS/IN	DUSTRY	
COMPLET	Elementary/Secondary (0	-12)	College (t-4 or 5	+)	e. Do NOT u	se retired.)			•				ł
₽	11th.					WIFE				AT HO	OME		
8	17. FATHER'S NAME (First, M							16. MOTI	HER'S NA	ME (First, Middle, Maiden	Sumame)		
B	BENJAMI		BASS							NIE			
2	19a, INFORMANT'S NAME (7	,,,		1	9b. MAILING	ADDRES	S (Street a	ind Number	or Rural F	oute Number, City or Town	n, State, Zij	p Code)	
	MR. ALAN S		STEIN		409 1	VALLI	EY M	EADOV	V CII	CLE REIST	RST	N. MWC	D. 21136
. 1	20a. METHOD OF DISPOSITI	n 3 X Remo	oval from State	cemetery, ci				rne of		DATE 20c. LO	CATION -	City or To	wn, State
	21. SIGNATURE OF FUNERAL SERVICE LIGHNSEE 122. NAME AND ADDRESS OF FACILITY												
	21. SIGNATURE OF FUREIN	L BEHVICE LIG	At 1	1//						BROS.,INC	7		
	Hyphe	u 1	XIII	eruge	1					TOWN RD.) MT	21215
	21 PART I. Enter the di	beses, or c	emplicatione the	t caused the d	eeth. Do	not enter	the mo	de of dy	ing, auch	sa cardiec or reepi	ratory er	rest,	Approximate
1	IMMEDIATE CAUSE (Fir		Liet only one cet	ise on each lin	е.								Intervel Between Onset and Desth
	disesse or condition reguliting in death) - e. Cuttle Inguinorid 3 hours												
	DIE TO OR AS A CONSEQUENCE OF:												
z	and tracked Useration of Sastuc Contests 18 hours												
유	Sequentially list conditions, If any, leeding to immediate												
CERTIFICATION	CAUSE (Disease or Inju		0,										
1	thet initieted events resulting in death) LAS		DUE TO	(OR AS A CONSE	OUENCE O	F):							
H	reediting in death) LAS		J										
	PART II. Other significa	nt condition	s contributing to	deeth but not	resulting	In the ur	nderivin	a cause o	liven in	Part I. 24s. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS
EDICAL			_				,			PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
										t YE\$ 2	M NO		OF DEATH?
Σ	DID TORACCO II	CE CONTE	NIDILITE TO CA	LICE OF DE	ATLL M	· C 🖂 ·	- E	1					1 TES 2 NO
PHYSICIAN:	DID TOBACCO U		CIBUIE IO CA		CE OF DEA			UNC	ERTAIN	1 2 1			
<u> </u>	EXAMINER?	J MEDIONE	HOPPITAL:			OTHE	R:						
¥ I	27, MANNER OF DEATH		1 Ninpatient 2		28b. TIM	-	alng Hom 28c. INJ		sidence	8 Other (Specify) 28d. DESCRIBE HOW IN	I III DV OO	CURED	
	t Natural 5	Pending	(Month, D		IN.	IURY M	WO	RK?	I NO	280. DESCRIBE HOW IN	IJURY OC	CURED	
BY	3 Cudoldo	nvestigation	26a, PLACE O	F INJURY — At h	ome term	street fact] 110	28f. LOCATION (Street a	and Alumba	and Ormal C	but Almaha
	. =	Could not be datermined	building,	etc. (Specify)	,,		tory, orno			City or Town, State)	nu numbe	r or norm n	oute Number,
COMPLET	29a. CERTIFIER												
Continues to the cause(s) and manner as stated. Continues to the cause Continues to the cau													
8	2 MEDI	CAL EXAMINE	R: On the basis of a	ramination end/or	Investigation	on, in my o	opinion, d	eath occur	ed at the	time, date and place, and	d due to ti	ha cause(s	and manner as stated,
BE	205 GIGNATURE AND TITES	OF CERTIFIER	()/)	M				29c. LICE	NSE NUM	BER	29d. DAT	E SIONEO	(Month, Day, Year)
2	1. Zohn	usc	rexe	147				D4	56	23	1	3/11/	75
F	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITI	M 27) (Type	, Print)	DI		N 1	10 111	1	-	10
	INK L. KU	ssell	8:41	602 D1	Libe	rtv	1/10	12a	lall	Kandalls	ston	my	1021133
	31. DATE FRED THOUNT DED	95 /	JA TO MALANGE MAIN	A'S SIGNATURE))	
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DIVISION OF VITAL RECORDS, P.O. BO

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR				CERTIF	ICAII	E OF	DEA	<u> </u>		REG. NO.			
	1. DECEDENT'S NAME (First, Midd JAMES HERBER		7ARTN	TD						2. DAT	e of DEATH	AY	(YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5.	SEX		s. last birthday)	IF UNDER		IF UNDER			E OF BIRTH		B. BIRTH	PLACE (State or Foreign
	212-84-6655		∑ M 2 □ F	3	4 YRS.	MONTHS	DAYS	HOURS	MIN.	SEP	T. 25,	1960	MAF	WYLAND
~	Sa. FACILITY NAME (If not institute					9b. CITY	r, TOWN	OR LOCATI	ON OF DE	EATH		9c. COU	NTY OF D	EATH
DIRECTOR	STELLA MARIS		CE			TO	OWSO!	N				B	ALTIM	IORE
E		COUNTY	·		10c. CI1	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY
듬	MARYLAND]	N/A		В	ALTIN	ORE							LIMITS?
AL	10e. STREET AND NUMBER				10f. ZIP CODE					VHAT COUNTRY?				
FUNERAL	1337 WINSTON AVENUE					21239						A		
5	11. MARITAL STATUS 1 X Never Married 2 Marrie		FORCES? 1			13.	WAS DEC	ENDENT C	OF HISPAN	IC ORIG	IN? (Specify Yea	or No-	14. RACE	— American Indian,
3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:									Specify: BLACK					
	15. DECEDEN	T'S EDUCATI	ION	184	. DECEDENT'S	USUAL O	CCUPATIO	ON		16	b. KIND OF BUS	INESS/INI	DUSTRY	BLACK
<u> </u>	(Specify only higher Elementary/Secondary (0-12)		college (1-4 or 5+	,	(Give kind of life. Do NOT u	work done se retired.)	during mo	st of working	ng					
COMPLETED	12		3		SUPPI	LY SP	ECI	ALIST	7		HOS	SPITA	L	
	17. FATHER'S NAME (First, Middle,							16. MOT	HER'S NA	ME (First,	Middle, Maiden	Surname)		
BE	JAMES HI	ERBER	<u> </u>	SHE	ARIN, S				LMA				WILL	IAMS
2	TANYA GRAY	unj									mber, City or Town			
	20s. METHOD OF DISPOSITION			20b. PL	ACE AND DATE	_). BP		MORE, M		LZ34	
ŀ	14 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐ Ramoval	from Stata	cemeter	y, cremetory or o	ther nlengt			3	/13			ORE,	1.552
	21. SIGNATURE OF FUNERAL SER	VICE LICENS	SEA			22.	NAME AF	D ADDRE	SS OF FA	CILITY				110.
	* John,	6	Jelor	\							ERAL HO			04
23. PART/. Enter the dieeeses, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory and shock, or heart failure. List only one cause on each line.										rest,	Approximate			
IMMEDIATE CAUSE (Final									interval Between Onset and Death					
	disease or condition resulting in death)	a	AID	S_										6yrs.
_		_	DUE TO	OR AS A CO	NSEQUENCE O	F):								0
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b	DUE TO	OR AS A CO	NSEQUENCE O	F):								
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	_ ه _												
E	that initiated events resulting in deeth) LAST	1	DUE TO (OR AS A CO	NSEQUENCE O	F):								
8	Webseld Steel	d												
	PART ii. Other significent co	onditions co	ontributing to	deeth but r	ot resulting	in the ur	nderlying	cause g	givan in	Part i.	24a, WAS AN		24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
EDICAL							_				1 TYES 2			COMPLETION OF CAUSE OF DEATH?
Σ														1 TES 2 NO
Z	DID TOBACCO USE C		UTE TO CAL				_	UNC	ERTAIN	И П				
PHYSICIAN:	25. WAS CASE REFERRED TO MED EXAMINER	Н	OSPITAL:		PLACE OF DEA	OTHER								
¥ I	1 VES 2 NO	10	Inpatient 2 28e. DATE OF		1 3 DOA		sing Hom 28c. INJ	e 5 🗆 Ra	aldence	-	er (Specify)	HOSE		
	1 Natural 5 Pendir	ng Igation	(Month, Da			IURY M	WO	RK7	NO	290, DE	SCHIBE NOW IN	SURT OC	COMED	
β Ω	2 Accident investi 3 Suicide 6 Could		28a. PLACE OF	INJURY — /	it home, farm,	street, tact	ory, office			28f. LO	CATION (Street a	nd Number	or Rural R	oute Number,
E	4 Homicide datam	nined	Juliani, i	ite: (Specify)						City	or Town, State)			
COMPLET	29a. CERTIFIER (Check only	G PHYSICIAN	: To the best of s	my knowledge	, death occurr	ed at the t	lme, data	and placa,	and dua	to the ca	use(a) and man	ner an stat	ed.	
One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner									and manner as stated.					
BE	29b. SIGNATURE AND TITLE OF CI	ERTIFIER	20 0					29c. LICE	NSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
2	Fraall	14	-ceul	kne	emp)		De	986	43		▶3	19/	45
	30. NAME AND ADDRESS OF PERS												1	
-	DR. KENDALL 31. DATE FILED (Month, Pay, Year)	r AULKI	32. REGISTRAF	R'S SIGNATUR	LANEY V	ALLE	Y RI)., I	OWSC)N,	MD 212	204		
	MAR 1 4 1995	5 Jul	in d'avole	orkard	14									

020	physician.
BALTIMORE, MARYLAND 21215-0020	hospital or attending physician
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2	hospital
4	the state
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MAR	eath. Page 6 may be retained by the hosp
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29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

PRITAM 5 SAIN MD 9/2

BE

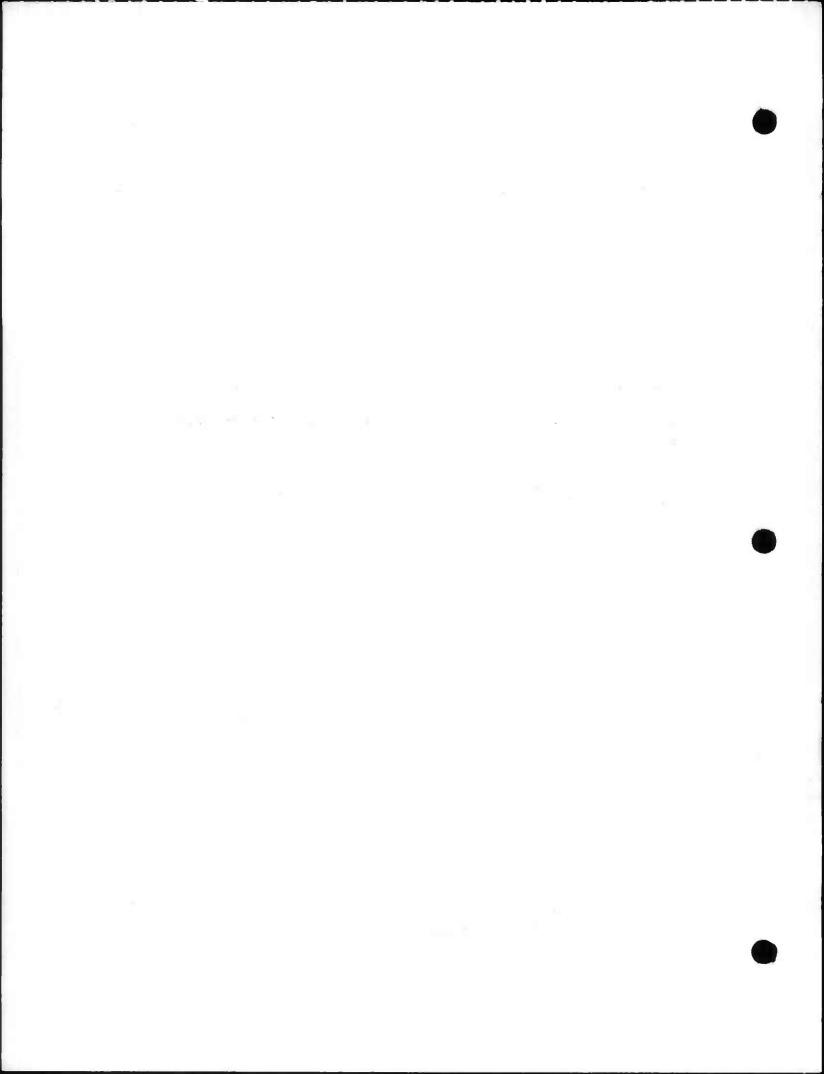
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 95 YEAR SPEDALERE MONTH 03 -ANNE 8128P# 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS 6. BIRTHPLACE (State or Foreign DAYS HOURS MIN 220-18-8276 1 M 2 X F YRS. June 2, 1926 Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Deaton Hospital and Medical Center DIRECTOR Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNT 10d. INSIDE CITY LIMITS? Maryland Baltimore Essex 1 TES 2XXNO FUNERAL 10e. STREET AND NUMBER tof. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 32 Stemmers Run Rd. burial-transit 21221 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2XXNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—It yea, specify Cuban, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: White 1 TES 2-NO BY Specify the 3 🔀 Widowed 4 🗌 Divorced use as COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) for Elementary/Secondary (0-12) College (1-4 or 5+) director, page 5 should be detached 12 Stenographer Legal 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) Ħ Alexander Emerson Loretta Bevan BE. notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Willard J. Emerson 522 Hilton Ave. Baltimore, Maryland 21228 pe 20s METNOD OF DISPOSITION
1 A Burlel 2 Cremation 3 Ramoval from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must MD Vetrans Cemetery 3/16/95 Garrison Forest, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENS examiner 22. NAME AND ADDRESS OF FACILITY
Bruzdzinski Funeral Home P.A. the funeral 1407 Old Eastern Ave. Balt. MD. 21221 medical 23. PART i. Entar tha diseases, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximate shock, or heart failure. List only one cause on each ilna. Interval Betwe 0 IMMEDIATE CAUSE (Final **Onset and Death** cremation, the disease or condition resulting in death) completely event, DUE TO (OR AS A CONSEQUENCE O bunal, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata cause. Enter UNDERLYING attending physician CAUSE (Disesse or injury that initiated events resulting in death) LAST 6 the atten Mental H 23 shows any Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO signed by the COMPLETION OF CAUSE 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. Item 2 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) State HOSPITAL certificate **EXAMINER?** OTHER:
4 X Nursing Home 5 Realdence 8 Other (Specify) 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED this c 28 is marked, 1 Natural BY 1 YES 2 NO 2 Accident death Investigation 28s. PLACE OF INJURY — At home, term, street, factory, office 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A COMPLETED 8 Could not be detarmined 4 Nomicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT: It item 2 29a, CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

CLOVEY LN #211 Lamel

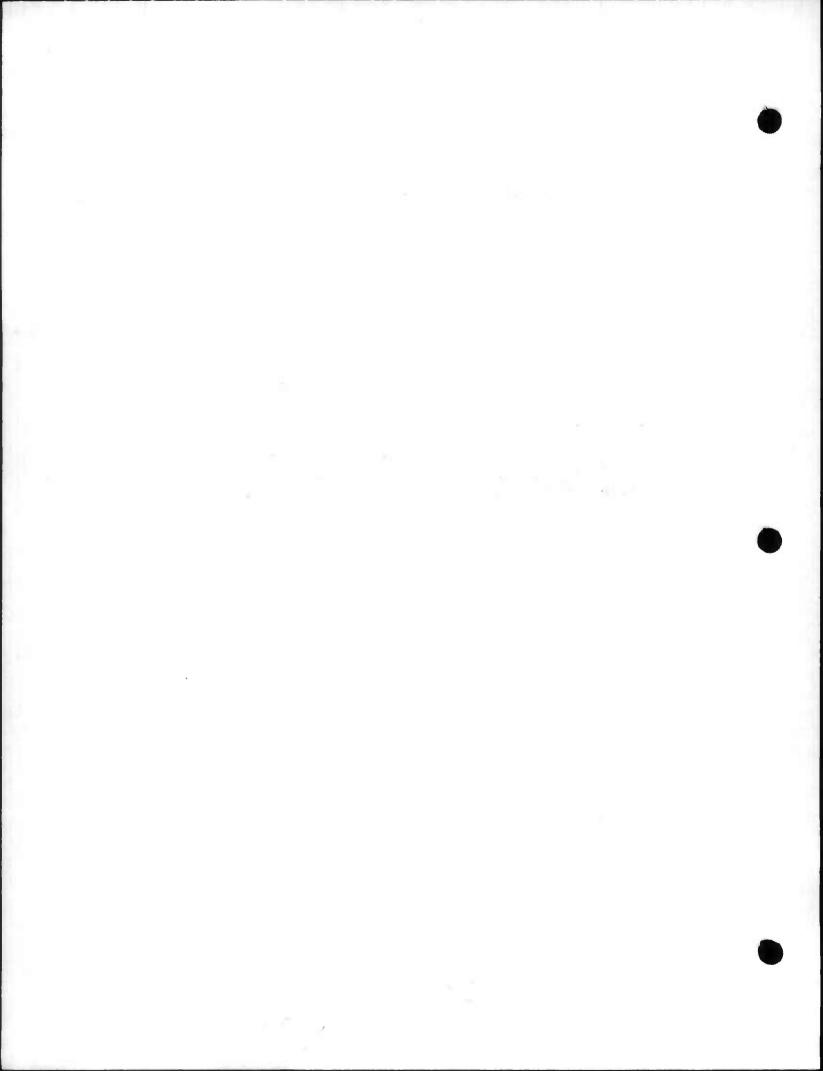
29d. DATE SIGNED (Month, Day, Year)



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and receive death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Memial Hyglene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

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		REGISTRAR		CE	HILL	AIEU	DEAL	н	REG. NO.			
		DECEDENT'S NAME (First, Middle, Last	Thomas V	William	Sears	5			2. DATE OF DEATH MONTH DA	1995	YEAR	3. TIME OF DEATH 8:51PM M
		4. SOCIAL SECURITY NUMBER 21.3-07-1181.	5. SEX 0	AGE (In yrs. las		F UNDER 1 YEAR DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 12/28/19	18	Country	PLACE (State or Foreign
		9a. FACILITY NAME (If not institution, give	street and number)		9	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNT				NTY OF DE	EATH	
TOP		Johns Hopkins	Bayview Med	dicalCI	R.	Balt	imore	City	7	1	N/A	
DIRECTOR	SINE	Maryland 106. coun	Baltimore	е	10c. CITY, 1	TOWN OR LOC	ATION	Dund	lalk			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	1	100. STREET AND NUMBER 581 South 47th	Street			of, ZIP CODE		224			HAT COUNTRY? States	
=		11. MARITAL STATUS	12. WAS DECEDENT 8			13. WAS D	CENDENT OF	F HISPANIC	C ORIGIN? (Specify Yes	or No	14 BACE	- American Indian
8	5	1 Never Married 2 Married 3 Widowed 4 Divorced	YES 2 N	MWII If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 ▼NO Specify:						Black, Specif	- American Indian, White, atc.	
8	i II	15. DECEDENT'S ED (Specify only highest grad		16a. DE(CEDENT'S US	UAL OCCUPAT k done during i	TON	7	16b. KIND OF BUS	INESS/IND	USTRY	
PLET		Elementary/Secondary (0-12) 7 Years	Polic	etirea.)	rost or working	,	Baltimo		ity			
Once.		17. FATHER'S NAME (First, Middle, Last)			POLIC	Gliair	I IN MOTH	ED'S NAM	E (First, Middle, Maiden)			
BE C		William Thomas	Sears						O'Leary	surname)		
TO B		19a. INFORMANT'S NAME (Type/Print)							oute Number, City or Town			
		Mrs. Mary D. Se						reet	Baltimo			1224
T Must		20e, METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Red 4 Donation 5 Other (Specify)				OF Jes		m. 3	/13/95 DI	indal	.k, M	un, state Varyland
examiner must be notified at once.	22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222											
	1	23. PART I. Enter the diseases, or	complications that	sed the de	eth. Do not							Approximate
medica	1	shock, or heart feilure IMMEDIATE CAUSE (Finel	List only one cause	on each line.	77				_	otory arr	oot,	interval Between
9		disease or condition resulting in death)	. ACUT	TE	PUL	MON	ARY	F	DEWA			i la su
T AGE		readiting in death)	DUE TO (O	R AS A CONSEC	UENCE OF):	1.0	- 1 1		1/10 1-10-1			1 - cour
CATION		Sequentially list conditions,	b. MYOC	R AS A CONSEO	LA CENTRAL	IM	FARC	271	ON			Mair
TATI		if sny, leading to immediate cause. Enter UNDERLYING	332 13 (0)	n AS A CONSEC	OENCE OF).							
TIFIC		CAUSE (Disease or injury that initiated events	DUE TO (OI	R AS A CONSEO	UENCE OF):							
		resulting in deeth) LAST	d									
		PART ii. Other significant condition			euiting in t	the underlyl	ng ceuee gi	iven in Pa			24b.	WERE AUTOPSY FINDINGS
EDICAL		DIABETES	MELL	(1705					PERFORI		1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEI							1				- 1	OF DEATH?
PHYSICIAN: M		DID TOBACCO USE CON	RIBUTE TO CAU	SE OF DEAT	TH YES	□ NO [UNCE	RTAIN				
5 5		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACI		Check only one						
X S		1 YES 2 DAO	1 Inpatient 2 I E		DOA 4	☐ Nursing Ho	me 5 DRes	Idence 8	Other (Specify)			
BY PHYSICIAN		27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF IN. (Month, Day,		286. TIME O	Y W	JURY AT ORK? YES 2 [28d. DESCRIBE HOW IN	JURY OCC	URED	
		3 Suicide 8 Could not be determined	28e. PLACE OF II building, atc	NJURY — At hor (Specify)	ne, farm, atre	et, factory, off	ce	2	281. LOCATION (Street or City or Town, State)	nd Number	or Rural Ro	oute Number,
		290. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the beat of my	knowledge, des	th occurred a	it the time, de	e and place o	and due to	the cause(s) and many		.4	
BE COMPLETED			ER: On the beals of exam									end manner sa stated,
O BE		29b. SIGNATURE AND TITLE OF CERTIFII KILMAN O'	onno	- /	M		29c. LICEN	H6	491	P DATE	3/9	195 Day Harry
		30. NAME AND ADDRESS OF PERSON W	OMM ON	P 5	27) (Type, Pri	HOPKI	INS	BAY	VIEW C.	IR	121	224
		MAR 1 4 1995	Full 32 0 FG 1720 3	Kereluti								



3. TIME OF DEATH 4-5 A

10d. INSIDE CITY 1 YES 2 NO

14. RACE — American Indien, Black, White, etc.

timore, Maryland

Approximate interval Between Onset and Death

FUNERAL DIRECTOR

BY

MPLETED

0

BY PHYSICIAN: MEDICAL CERTIFICATION

COMPLETED

BE

2

1 - FOR STATE REGISTRAR	,	STATE OF MA					HEALTH AND I	MENTAL HYGIEN	_		
1. DECEDENT'S NAME (First,	, Middle, Last)	0.50	tohn di	WR'T	huart	Z		2. DATE OF DEATH DO	AY (7 YEAR	3. TIME OF DEAT
4. SOCIAL SECURITY NUMBER 22 00 9 1	H159	5. SEX 8.	AGE (In yrs.	last birthday) YRS.	IF UNDE	DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Ct. 24, 19	918	Country	PLACE (State or Fi
90. FACILITY NAME (If not in	SAM	ARITAW	110	sp.	9b. CI)	OR LOCATION OF DE			A	EATH
10e. STATE	10b. COUNT						ATION			-	10d. INSIDE CITY
Maryland	Balt	imore		Du	ında]	lk					LIMITS?
10e. STREET AND NUMBER				_		1	Ot. ZIP CODE		10g. CIT	FIZEN OF W	HAT COUNTRY?
3003 Liberty Parkway							21222		Unit	ted S	tates
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES GIVE WAR OR DAY WW II				2 NO If yes, specify Cuben, Mexica			in, Puerto Ricen, etc.)			— American India, White, etc.	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work					USUAL C	OCCUPAT	ION nost of working	16b. KIND OF BUS	SINESS/IN	DUSTRY	
Elementary/Secondary (0	-	College (1-4 or 5 +)		life. Do NOT u	se retired.))	iosi or working				
12th			Ma	<u>chinis</u>	st_			AT&T			
17. FATHER'S NAME (First, M.	iddle, Last)	-					18. MOTHER'S NA	ME (First, Middle, Malden	Surname)		
Max Schwart	Z						Marie Wa	alter			
190. INFORMANT'S NAME (7)	ype/Print)			19b. MAILING	ADDRES	SS (Street	and Number or Rural F	Route Number, City or Town	n, State, Zi	ip Code)	
Alma A. Sch	wartz			3003 I	Liber	rty	Parkway	Baltimore	, Ma:	rylan	d 21222
20e. METHOD OF DISPOSITE		and form Circle	20b. PLA	E AND DATE	OF DISPO	SITION //	Verne of	DATE 20c. LO	CATION -	- City or Toy	wn, State
4 Donation 5 Other		oval from State	Gard	ens of	E Fa:	ith	Cemetery	3-11-95 1	Balt	imore	Marvi
21. SIGNATURE OF FUNERAL	L SERVICE LI	CENSEE	///				AND ADDRESS OF FAC			2.1020	, raily 1
1 (har	Mh	tinh	1		170	922	Wise Aver	eral Home o	lk N	Marzi	k, Inc.
23. PART i. Enter the di	seases, Dr	complications that co	nysed-the	desth. Do i	not anta	r tha m	oda of dying, suci	y as cardiec or respi	ratory a	rest.	Approxim
IMMEDIATE CAUSE (Fin		COA	-91	CLO	HF	IF	HT, H	repayo no	nal	Jyn.	Onset and
disease or condition resulting in dasth)	→	. CAR	CIN	JOM	A	1	ectum	S/PAP)	rese	ction	12/16
		DUE TO (OF	AS A CON	SEQUENCE O	F):			//			
Sequantially list conditi	000	1414	= 10	FIB	KO.	213	>				To
and resulted in a country	DITE,	DUE TO (OR	AS A CON	SECURENCE O	E.						-

if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated evants resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF) HEART DISEASE CORONARY DUE TO (OR AS A CONSEQUENCE OF): RRHOSI LIVER PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH?

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLAC	E OF DEATH (Chec						
	1 Inpatient 2 ER/Outpatient 3	DOA 4 N	ursing Home 5 🗌 Residence	8 C Other (Specify)				
27. MANNER OF OEATH 1 Metural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED				
3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At hor building, etc. (Specify)	me, ferm, street, te	ectory, office	28t. LOCATION (Street end Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER								

of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the b

ation end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner ee stated. 29d. DATE SIGNED (Month, Day, Year)

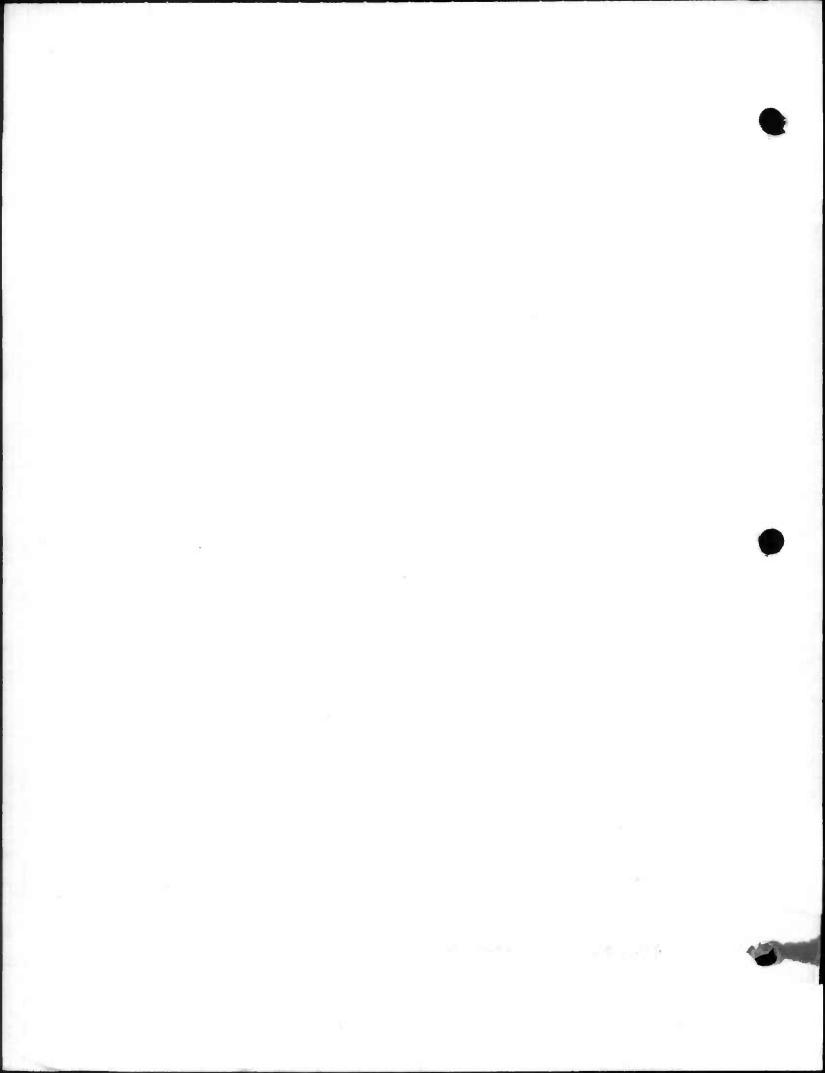
D0927 DMPLETED CAUSE OF DEATH (LTEM 27) (Type, Print)

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a few mounts after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certific	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending pl be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other	

	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND / D	EPART	TMENT 0	F HE/	ALTH AI	ND ME	NTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) MARIE EVELYN SERI()						2.	DATE OF DEATH	AY	YEAR 995	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 213-20-9868	1 ☐ M 2 🏋 F	AGE (In yrs. last bit		IF UNDER 1 YE		OURS N	EM	DATE OF BIRTH (Month, Day, Year) OCT. 21, 19			ACE (State or foreign
OR	9a. FACILITY NAME (N not institution, give str 2503 BANGER STREET				9ь. СІТУ, ТОУ ВА		OCATION 10RE			9c. COUN	TY OF DEA	
DIRECTOR	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND BAI	TIMORE C		Oc. CITY	TOWN OR LO		ГІМОБ	F				od. INSIDE CITY
FUNERAL (100. STREET AND NUMBER 2501 BANGER STREET						2123					AT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT B	YES 2 NO)	It yes	, specif	DENT OF H	ISPANIC O	RIGIN? (Specify Yes erto Rican, etc.)		14. RACE -	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 7TH GRADE	ATION completed) College (1-4 or 5+)	(Give A	NOT use	JSUAL OCCUP ork done during retired.)	ATION most o	working		16b. KIND OF BUS	SINESS/INDU	STRY	WILLE
COM	17. FATHER'S NAME (First, Middle, Lest) CECIL RAGSDALE				- CER		MOTHER MYRTI		First, Middle, Maiden		ING	
TO BE	190. INFORMANT'S NAME (Type/Print) MR. JAMES F. SERIO	SR.	19b. M. 31.	AILING A	ADDRESS (Str	et and i	Number or I	Rural Route	Number, City or Town		Code) 009	
	20a, METHOD OF DISPOSITION Disputation 2 Cremation 3 Remo Donation 5 Other (Specify)		20b. PLACE AND cemetery, cremeter MEADOWI	ory or oth	er plecel			ARK 3		CATION — CI		, State
	21. SIGNATURE OF FUNERAL SERVICE CIC	mith			HUBE 4107	ARD WI	LKEN	ERAL S AVI	HOME, IN	TIMORE	E, MD	21229
	23. PART I. Enter the diseases, or co- shock, or heart feiture. L IMMEDIATE CAUSE (Finel disease or condition resulting in death)	iat only one cause	TE CAY	oli NCE OF	c Ph	lvh	of dying,	such as	ARR	EST	et,	Approximate interval Between Onset and Death Minutes
CERTIFICATION	Sequentistly list conditions, if sny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		AS A CONSEQUE	NCE OF)	:	tc	Can	dib	Dise	AR		months
MEDICAL	PART II. Other eignificant conditions				tha underl	\/			PERFOR	MED?	AM CC OF	ERE AUTOPSY FINDINGS ALLABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF	F DEATH	(Check only o	ne)	UNCER.					
BY PHYS	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	1 Inpatient 2 El 28a. DATE OF IN. (Month, Day,	IURY 28	b. TIME	OF 28c.	INJURY WORK?	_	28d	Other (Specify) DESCRIBE HOW IN	JURY OCCU	RED	
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF IP building, etc.	IJURY — At home, (Specify)	farm, str	reet, factory, o	ffice		281.	LOCATION (Street a City or Town, State)	nd Number or	Rural Rout	e Number,
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER.	AN: To the best of my										nd manner ea stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	imai	ikn.	m	ו טי	294	SE LICENSE	NUMBER	D 002	29d. DATE S	Ma	onth, Day, Year) roh 14,
	DR. HENRY ARMANAS 31. DATE FILED (Month, Day, Year)	- 1934 WI	LKENS AV			ALT]	MORE	,	MARYLAND	21	223	1 9975
	MAR 1 4 1995	32. REGISTRAR'S	Regist								.10	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death, Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, gage 5 should be detached for use as the burial-transit nermit Panes 1 2 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burlal, cremation, or removal,
IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

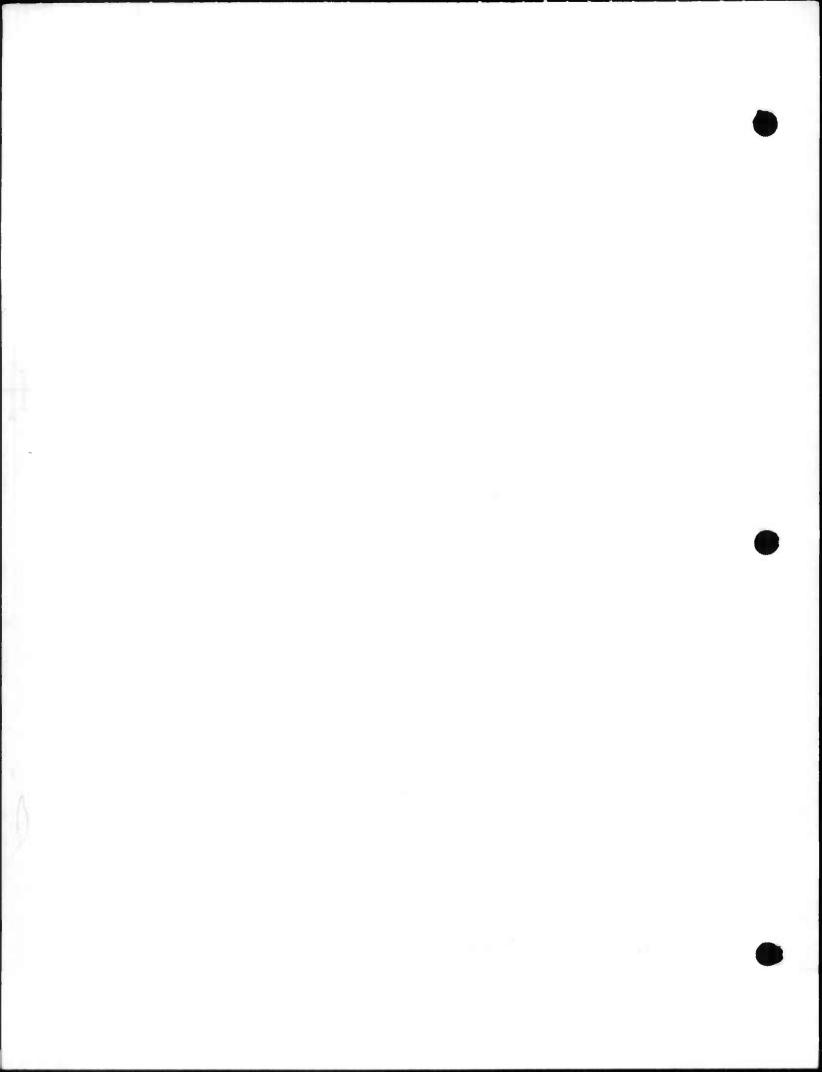
											15 1	1/600
	1 - FOR REGISTRAR		RYLAND /	DEPAR ERTIF	TMEN	T OF H	EALTH DEAT	AND I	MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, MICHOLO, LIST) VINGINIA MARY		4						11.	AY O	VEAR	. TIME OF DEATH 23:20 M
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. le:	st birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			ACE (State or Foreign
	216-28-5109	1 🗆 M 2 💢 F	82	YRS.	MONTHS	DAYS	HOURS		MAY 20, 19	12		YLAND
~	9e. FACILITY NAME (If not institution, give				9b. CIT	y, TOWN C	R LOCATIO				UNTY OF DEA	
DIRECTOR	ST. AGNES HOSPITA	L					BALT1	MOR	E	BA	LTIMO	RE CITY
EC	10a. STATE 10b. COUNT	TY .		10c. CIT	Y. TOWN	OR LOCAT	ION					0d, INSIDE CITY
HO	MARYLAND BA	LTIMORE				BA	LTIMO)RE				LIMITS?
1	10e. STREET AND NUMBER						ZIP CODE			10g. CIT		AT COUNTRY?
FUNERAL	1106 OAKLAND TERR	ACE ROAD					2	122	7	II.	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AF	RMED	13.	WAS DEC	ENDENT OF	F HISPAN	IC ORIGIN? (Specify Yes			- American Indien, White, etc.
ВУ Е	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1		NO		If yes, spe	2X NO	Specify	n, Puerto Rican, etc.)		Black, V Specify:	
		<u> </u>										WHITE
1	15. DECEDENT'S EDU (Specify only highest grad	e completed)	16a. DE	ECEDENT'S Silve kind of a Do NOT us	work done	during mos	IN st of working	9	16b, KIND OF BUS	SINESS/IN	DUSTRY	
PLE	Elementary/Secondary (0-12) 8TH GRADE	College (1-4 or 5+)	- 1	CHINI					AMERICA	NI CAI	N COM	D A NTY
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1 121	OHILM	011	DICA I		FR'S NAI	ME (First, Middle, Meiden		N COMP	ANY
Ü	GEORGE FULLER						1000		E LITTLE	Surrienne)		
m	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street e			loute Number, City or Tow	n, State, Zi	ip Code)	
2	MRS. MARLENE McN	ULTY							BALTIMORE,		21227	,
	20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Ren		20b, PLACE	AND DATE	OF DISPOS	SITION (Na	me of		DATE 20c LO		- City or Town	
	4 Donation 8 Other (Specify)	IOVAL FROM State	BALTI	matory or o MORE	NAT	IONAI	CEM	ETER	RY 3/15 B	ALTI	MORE	
	21. SIGNATURE OF SUNERAL SERVICE LI	Compet	2		22.	NAME AN	D ADDRES	S OF FAC	CILITY		TOTAL	
	Tous (.)	8 mitt)						AL HOME, II		DE M	01000
	23. PART i. Enter the diseases, or	complications that c	auead the de	eath. Do r	not enter	the mo	de of dyir	ng, such	es cardiec or reepi	iratory ar	reat,	21229 Approximata
	shock, or heart failure. IMMEDIATE CAUSE (Final	List only one cause	on each line	1.						-0.5		interval Between Onset and Death
		a. Myocan	rdish	In	fare	tion	1 .					3 Smin
		OUE TO (OF	AS A CONSE	QUENCE O	F):				0 1	_	-0	- "
Z	Sequentially list conditions,	a Pleural	Effusio:	nicon	solid	lation	N; 50	PSis	s; Rospinato	24 40	culue	25d
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	De ro (or as a consequence or): Exploratory Lap and Resection; Pyloroplasly firunca vagoromy 30 d. Due to (or as a consequence or): Oue to (or as a consequence or): Oue to (or as a consequence or): (2/0)										
S	CAUSE (Disease or injury	DUE TO (OF	AS A CONSE	and a	. Kese	ecliv	n; ly	Lorol	plasty tirus	ncalv	ragohom	y 300.
Ē	that initiated events resulting in death) LAST	. Perforate	dding	to so al	11/0	an 1	מונח	91	Q	(2/10	ア -	1 30d.
CE						1	J					
AL	PART il. Other algnificent condition	18 contributing to de	ath but not r	reauiting i	in the ur	ndariying	cause gi	iven in i	Part i. 24a. WAS AN			ERE AUTOPSY FINDINGS
20	NON€.								1 YES 2	W NO	CC	OMPLETION OF CAUSE F DEATH?
ME									_ /		- 1	☐ YES 2 1 NO
ÿ	DID TOBACCO USE CONT	RIBUTE TO CAUS					UNCE	RTAIN	I V			
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		E OF DEAT	OTHE!							
₹	1 ☐ YES 2 ☑ NO 27. MANNER OF DEATH	1 Inpetient 2 I EF		DOA 28b. TIM	4 🗆 Nur	sing Home		idence	6 Other (Specify)			
	1 Natural 5 Pending	(Month, Day,	LI CA BLE		URY	28c. INJU			28d. DEŞCRIBE HOW II	NJURY OC	CURED	
ВУ	2 Accident investigation 3 Suicide Could not be	28e. PLACE OF IN	NJURY — At ho	me, ferm, s	treet, fect			NO	201. LOCATION (Street o	and Numbe	y or Sural Bour	to Mumber
日	4 Homicide determined	building, atc.	. (Specify)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town, State)	no mombe	O FIGURE FIGURE	in Ivamon,
COMPLET	290. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my	knowledge de	with occurre	ed at the t	lmo dete	and place	and due				
M	(Check only one) 2 MEDICAL EXAMINI											nd manner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIE		4				29c. LICE!			,		
BE		Jusanz	ray]	E SUR	G EK Den	7		05			3 10	onth, Day, Year)
임	30 NAME AND ADDRESS OF DEDSON WA			VESI	~ E-14	1			-	-	-1101	P-

RESIDENT 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KULDEEP SINGH. M.D. DEPTT. OF SURG. ST. AGNES HOSPITAL, BALTIMORE, MD. 21229

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



3. TIME OF DEATH

DHMH-18 Rev 1/89

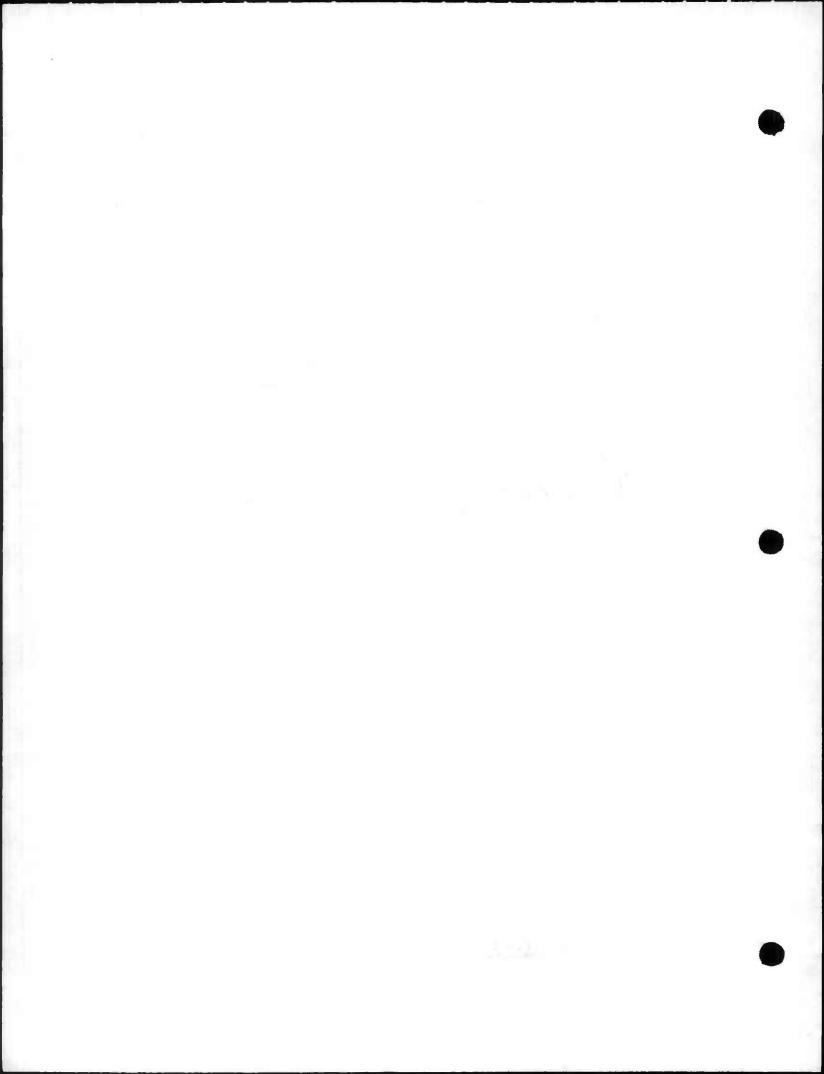
DIVISION	DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
TO THE FUNERAL DIRECTOR; After	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and complete
be filed within 72 hours after death	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, crem
IMPORTANT: If item 28 is ma	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event,

1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Francis adol Seebergee 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 212-05-7416 1 X M 2 | F 88 DAYS HOURS YRS Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give atreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR ST. AGNES HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE CATONSVILLE permit. FUNERAL 10e. STREET AND NUMBER 715 MAIDEN CHOICE LANE - HB-517 funeral director, page 5 should be detached for use as the bunial-transit 21228 retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried BY 3X Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) ENGINEER 12TH GRADE 17. FATHER'S NAME (First, Middle, Lest) JOHN F. SEEBERGER.SR. 16 BE notified 19e. INFORMANT'S NAME (Type/Print) 2 JOHN F. SEEBERGER, III Раде 6 тау be 9 20a. METHOD OF DISPOSITION
1 ☐ Burlet 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must 4 Donation 5 Other (Specify) GREENMOUNT CREMATORY 21. SIGNATURE OF FUE examiner BAL BERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY cuted within 24 hours after de-d completely filled in by the ful-unal, cremation, or removal. medicai ahock, or heart fellure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finei the disease or condition End stage conge DUE TO (OR AS A CONSEQUENCE OF): resulting in death) executed within traumatic event, in and com to burial, o Coronares arlete CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate signed by the attending physician Health and Mental Hygiene prior to certificate be cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events cellettes . Enter UNDERLYING other DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST 0 Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. the MEDICAL that any 1 h vom bout pence shows t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) certificate t Item HOSPITAL: OTHER: 1 YES 2 NO 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY marked, 28c. INJURY AT this (1 Natural
2 Accident 1 YES 2 NO After ti BY OR ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) DIRECTOR; A hours after de item 28 is ETED 3 Suicide 6 Could not be determined 4 Homicide hours item

HONTH 05:40 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign JUNE 19,1906 MARYLAND 9c. COUNTY OF DEATH BALTIMORE CITY 10d. INSIDE CITY 1 YES 2 X NO 10a, CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY BALTIMORE GAS & ELECTRIC CO. 16. MOTHER'S NAME (First, Middle, Maiden Surname)
BARBARA SCHLEE 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)

2288 MEADOWS DRIVE —MORGANTOWN, W. VA. 26505 20c. LOCATION — City or Town, State BALTIMORE HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata **Onset and Death** 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO 4 ☐ Nursing Home 5 ☐ Reeldence 8 ☐ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29e. CERTIFIER 1 Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. COMPL MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. 206. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D45530 3 -8-95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SIVASALLAM 900 Caton Ale terrose 21229 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE



page 5 should

funeral director,

completely

attending physician

has

certificate

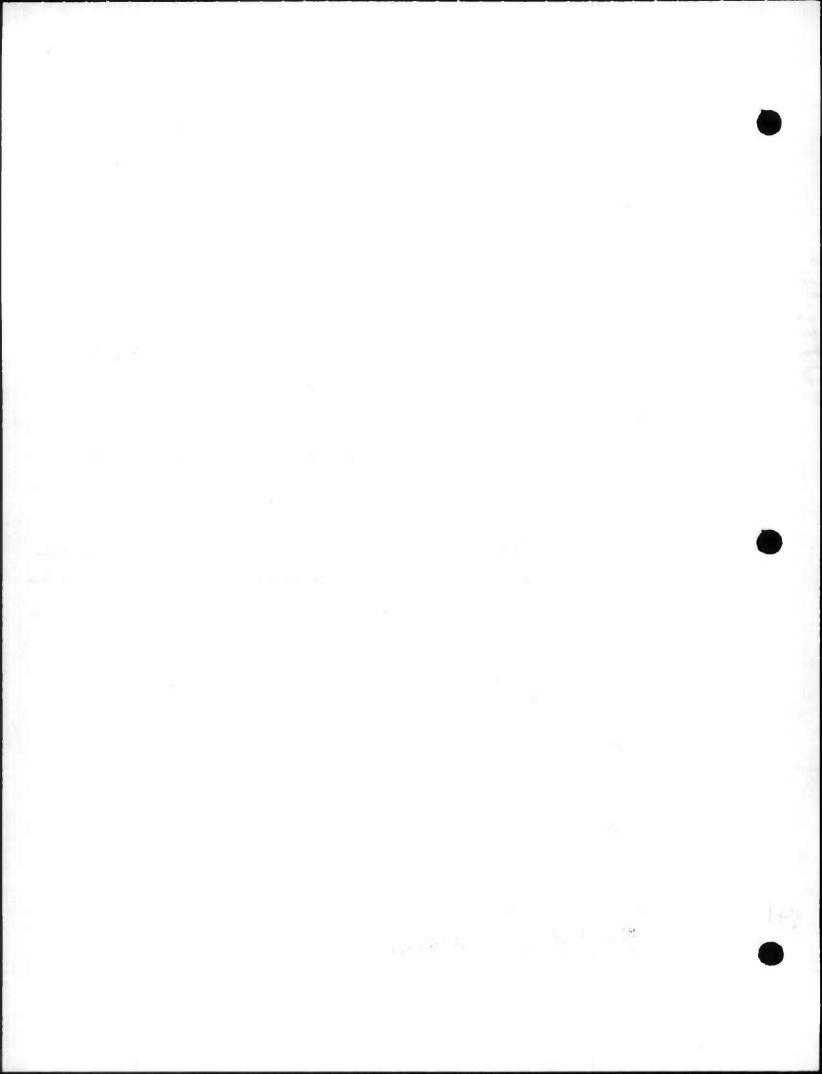
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use as the burial-transit permit. Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH YEAR GILBERT M. STANLEY 5.19 MARCH a M 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 218-18-7095 1 M 2 - F January 3. Indiana 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital Baltimore N/A RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Arbutus 1 TES 2 1 NO FUNERAL 10e. STREET AND NUMBER 101 ZIR CODE 10g. CITIZEN OF WHAT COUNTRY? 4721 Benson Ave 21227 USA 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, While, etc. FORCES? 1 YES 2 NO 1 Never Married 2 X Married 1 TES 2 NO Specify: BY Specify: white 3 Widowed 4 Divorced WWII COMPLETED 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A Tool & Dye Maker Krug Machine Shop 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Elmer L. Stanley Ħ BE Freda L. Beer notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 4721 Benson Ave., Baltimore, Md. Mary I. Stanley pe 20a. METHOD OF DISPOSITION
1 Burtal 2 Cremation 3 0
4 Donalion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must t DATE 3/10 The Green Mount Cemetery Baltimore, Md. 21. SIGNATURE OF PUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227 filled in by the fillen, or removal. 0 23. PART I. Enter the dieaeses, or complications that codeed the deeth. Do not enter the mode of dying, auch as cerdiac or respiratory errest, ahock, or heart failure. List only one cause on each line. medicai Interval Between IMMEDIATE CAUSE (Final Onset end Death cremation. the disease or condition resulting in death) BRONCH ITIS event, 2 weeks DUE TO (OR AS A CONSEQUENCE OF): in and com to burial, c HEART FAILURE traumatic CONGESTIVE 2 weeks CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING prior RIGHT VENTRIGE (HEART) DYSFUNCTION CAUSE (Disease or Injury Diears other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST 10 Menta injury. signed by the a Health and Ment PART II. Other eignificant conditions contributing to death but not recuiting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any ALCOHOLISM COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO CORONALY ARTERY DISEASE 1 YES 2 NO Jo DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item HOSPITAL: 1 YES 2 140 OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, with 1 Netural 1 YES 2 NO BY After Investigation 2 Accident DIRECTOR: At hours after de item 28 is n 3 Sulcide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT: If Item 2. 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end piece, end due to the cause(s) and manner as attated. 2 _ MEDICAL EXAMINER: On the basis of examinstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as attated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Klande, M.D. March 9 1995 2066 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HOSPITAL, BALTIMORE, MD 21229 R. PANDE, ST. AGNES 31. DATE FILED WAR

32. REGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.		
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	10 0	2 ho	PORTANT If Item 28 is marked or Item 23 shows any Injury or other traumetic event the medical aversions must be availabled at some
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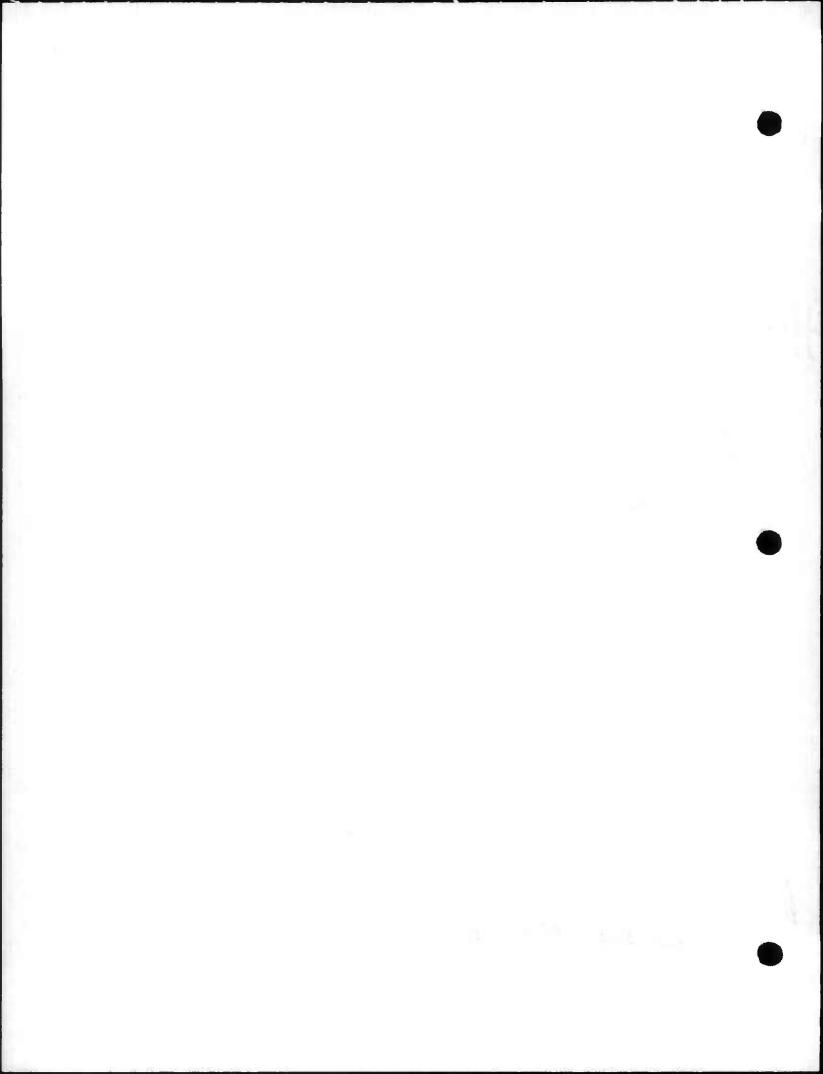
1. DECEDENT'S NAME (F.		S^1+	ysiak				DEATH	2. DAT	REG. NO		YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NU		5. SEX	6. AGE (In yrs.	fact birthday)	IF UNDER		IF UNDER 24 H	Ma	rch 12	, T	195	8:45 A
213-28-63	336	1 🔯 M 2 🗆 F	63	YRS.	MONTHS	DAYS	HOURS M	Jul	E OF BIRTH oth, Day, Year)	1931	Count	ryland
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RESIDENCE OF D	ECEDENT						54011		-		110.	-
Maryland	Har	ford		1111111111	ry, town o		TION					10d. INSIDE CITY LIMITS? 1 TYES 2 TO NO
3339 Deep		Court			_	101	ZIP CODE	.009		_	S.A	WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 D	Married	12. WAS DECEDEN	YES 2		1 1	If yes, sp		SPANIC ORIG	IN? (Specify Ye Rican, etc.)		14. RAC	E — American Indian, k, White, etc.
(Specify	ECEDENT'S EDU	completed)		DECEDENT'S (Give kind of Me. Do NOT u	work done o	CCUPATIO	ON st of working	16	b. KIND OF BU		DUSTRY	
Elementary/Secondary		College (1-4 or 5	+)		hini	st			Can Natio	onal	Can	Co.
17. FATHER'S NAME (First, James	P. Sol	tysiak							Middle, Meider	,		
William F	(Type/Print)						nd Number or F	iural Route Nur	mber, City or Tox	vn, State, Zip		
20a. METHOD OF DISPOS		ysiak	20h 9l Al	フフフラ CE AND DATE		_			ngdon,	CATION -		
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4 🗌 Donation 5 🗆 Ott	ver (Specify)		cemetery,	Cath	edra.	1 Ce	med emeter	y 3/1	5 Bal	timo	re.l	Maryland
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be med whithin it many after death with the State Orght, by headth and method hydrin burlar, or territoral. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSP	TO THE FUNE	IMPORTANT	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	IEALTH AND !	MENTAL HYGIEN		
33	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATH
- 17	HERBERT EUG	BENE 3	STEVENS	5		March I	Y YEAR	1215 "
	4. SOCIAL SECURITY NUMBER 5			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign
1/2	172–18–0498	M 2 □ F	76 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Jan. 27,1	919 Per	nsylvania
	9a. FACILITY NAME (If not institution, give street	,		96. CITY, TOWN (OR LOCATION OF DE	ATH	9c. COUNTY OF	
DIRECTOR	St. Agnes Hospital	L	[Balti	more		V.	I/A
ธ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY							
<u>=</u>		Baltimore	10c. CITY,	Coton	sville			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER							1 TYES ZXXNO
RA	140 N. Symington A	\venue		101	212	28	10g. CITIZEN OF	WHAT COUNTRY?
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	1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO			IC ORIGIN? (Specify Yes n, Puarto Rican, etc.)		E — American Indian, ck, White, etc.
ВУ	3 Widowed 4 Divorced	W W II	ATES	1 TYES	2 NO Specify		Spe	White
O.	15. DECEDENT'S EDUCAT	ION	16a. DECEDENT'S U	SUAL OCCUPATION	ON .	16b. KIND OF BUS	INFRS/INGLISTRY	WILLCE
E	(Specify only highest grade con Elementary/Secondary (0-12)	ripleted) College (1-4 or 5 +)	(Give kind of wo	rk done during mo retired.)	st of working	100.11.11.0 01.000	MC55/MC55/M	
릴	8		Bottle	Capper		7-Up Bo	ttling C	ompany
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAI	ME (First, Middle, Maiden		
BE	William Stevens				Roseanne	e Lynch		
5 B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ODRESS (Street a	nd Number or Rural R	loute Number, City or Town	n, State, Zip Code)	
-	Helen Stevens (Spo	ouse)	140 N.	Syming	ton Aveni	ue Baltim	ore, Mary	land 21228
	20a. METHOD OF DISPOSITION 1 Sp Burlal 2 Cremation 3 Remova	from State	PLACE AND DATE OF	DISPOSITION (Ne	me of	DATE 20c. LOC	CATION — City or T	
- 19	4 Donation 6 Dother (Specify)	Ne	etery, cremetory or other w Cathed	ral Cem	etery	Bal	timore,	Maryland
	21. SIGNATURE OF FUNERAL PERVICE LICENS	SEE	7	122. NAME AN	M & PIIS	sell C Wit	zke Fune	ral Homes
	Lusselle	Vettel						le Maryland
	23. PART I. Enter the diseases, or com	plicetions that ceused	the desth. Do no	t enter the mo	de of dying, such	an cardiac or respir	ratory arrest,	Approximate
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	rooding in death)	DUE TO (OR AS A	CONSEQUENCE OF):					1/
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2	CAUSE (Disease or injury	DUE TO (OR AC A	CONSEQUENCE OF:					
	that initisted events resulting in deeth) LAST	DOE TO (OR AS A	CONSEQUENCE OF):					i
CERTIFICATION	d							
4	PART II. Other aignificent conditions c	ontributing to deeth be	ut not resulting in	the underlying	cause given in I			. WERE AUTOPSY FINDINGS
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ME	BOFD -	Pialer	www.	fle	lun			1 YES 2 NO
ž	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIN	<u></u>		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH					
SI	The second secon	OSPITAL: Inputiant 2 ER/Output		OTHER: Nursing Home	5 - Rasidenca	5 Other (Specify)		
H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME		JRY AT	26d. DESCRIBE HOW IN	JURY OCCURED	
В	1 Niltural 5 Pending 2 Accident Investigation				ES 2 NO			
ED	3 Suicide 6 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY building, atc. (Speci	— Al home, farm, str	eet, factory, office		261. LOCATION (Street at City or Town, State)	nd Number or Rural	Route Number,
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립		N: To the best of my knowle						
COMPLET	one) 2 MEDICAL EXAMINER: C	On the beals of examination	and/or investigation,	In my opinion, de	eath occured at the t	lime, data and placa, and	dua to the cause(a) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	1 - 1			29c. LICENSE NUM	BER	29d. DATE SIGNED	(Mighth, Day, Year)
TO B	(klejanola)	supe &	2		20888	2	> 3/11	19 -
	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, P	rint)			11	
	24 DATE FILED (March Co. V.							
	MAR 1 4 1995 Julia	2. REGISTRAD SIGNA	TURE					
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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

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		1. DECEDENT'S NAME (First, Middle, Last) Minnie Ro	senberg	Soch	ard				2. DATE OF MONTH March	D	AY T	YEAR 3	10:00	
		4. SOCIAL SECURITY NUMBER	5. SEX		s. lest birthday)		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH		B. BIRTHPL	ACE (State or Fo	
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3 should	œ	9e. FACILITY NAME (If not Institution, give						R LOCATION OF O	EATN		9c. COUNT	Y OF DEA	TN TO I	K
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sades	DIRECTOR	Marcal and Marcal					OR LOCAT					1	od. INSIDE CITY	
ŧ		Maryland Mont	tgomery		Ch	evy	Cha	. SE					☐ YES 2 🗓	NO
n. ansit pe	FUNERAL	2805 Blaine Drive					1.00	815			USA		AT COUNTRY?	
attending physician. se as the burial-transit permit. Pages 1, 2,	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 20 IF YES, GIVE WAR OR DATES			NO	13	If yes, sp	ENDENT OF NISPAI ocity Cuben, Mexico 2 NO Specif	n, Puerto Rica	Specify Yes in, atc.)		4. RACE - Black, V Specyly: Whit	- American India	en,
r attend use as	ED	15. OECEDENT'S EDU (Specify only highest grade		164	DECEDENT'S	USUAL	OCCUPATIO	ON .	16b. KII	ND OF BUS	SINESS/INDU			
spital or ed for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +		(Give kind of a life. Do NOT us	se retired.) duning mo	st of working	Env:		ment		rotec	tio
by the	BE CO	17. FATHER'S NAME (First, Middle, Last) David Rosenberg	1					16. MOTNER'S NA Ruth Ka		lle, Maiden	Surname)			
retained to S should notified		190. INFORMANT'S NAME (Type/Print) Irving I. Socha	ard					above	Route Number,	City or Town	n, State, Zip C	Gode)		
e ab		20e. METHOO OF DISPOSITION		20b. PL/	CE AND DATE	OF OISPO	SITION /Na	me of	DATE	20c. LO	CATION CI	ty or Town	. State	
Page 6 ma Il director, p		1X Buriel 2 Cremetion 3 Rem 4 Donatton 5 Other (Specify)		Jude	an Me	ther place	Gdn:	s. 3/3/	95		ey, N			
death. Pag tuneral di examiner		21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE			22	Ives	-Pears	oury on Fu	nera	1 Ho	mes		
after after y the Trova	Н	23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate												
filled in or he m		shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition	List only one cau	se on aach	iina.			arction		огтеврі	retory arres	.,	Interval Be Onset and	etween Death
within pletel crema		resulting in death)			NSEQUENCE OF		Inra	arction	<u> </u>				l ho	ur
executed and con o burial,	Z	Sequentially list conditions					Hea:	rt Dise	ase				20 yea	ars
ficate be execut physician and one prior to buri	ATIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CALISE (Disagra or Injury. C. Diabetes Mellitus												
phy ne p	CERTIFICATION	CAUSE (Disease or injury that initiated events	c. DIAD	OR AS A CO	NSEONENCE OF	tus P:	5						20 yea	ars
th H	EHI	resulting in death) LAST	d											
the d		PART II. Other significant condition	ns contributing to	death but n	ot resulting	in the u	nderiying	cause given in	Part i. 24	. WAS AN			ERE AUTOPSY FI	
uires that signed by Health an	MEDICAL								11	PERFOR		C	MILABLE PRIOR OF COMPLETION OF C	
of of		DID TOPACCO HISE CONT	DIDLITE TO CAL	UCE OF B	FAT1: \/=							1	YES 2 N	10
has the Dept	IAN	DID TOBACCO USE CONT. 25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CA		PLACE OF DEAT			UNCERIAII	<u>ч </u>			1		
SICIAN: The certificate I the State , or item	PHYSICIAN:	EXAMINER? 1 TYES 2 XNO	HOSPITAL: 1 Inpatient 2	ER/Outpatier	n 3 🗆 DOA	OTHE 4 Nu		5 K Reeldence	6 Other (Sp	pecify)				
PHY this	ву РН	27. MANNER OF DEATH 1 X Netural 5 Pending 2 Accident Investigation	26e. DATE OF (Month, Da		26b. TIMI INJ	E OF URY M	28c. INJU WOI 1 Y	JRY AT RK? ES 2 NO	28d. DEŞCRI	BE HOW IF	JURY OCCU	RED		
TTENDI TOR: A after d		3 Suicide 6 Could not be determined	28e. PLACE Of building,	F INJURY — A atc. (Specify)	t home, farm, s	street, fac	ctory, office		281. LOCATIO City or To	ON (Street e own, State)	nd Number or	Rural Rout	e Number,	
	COMPLETED	29e. CERTIFIER (Check only one)												
	CO	2 MEDICAL EXAMINE		amination end	I/or investigatio	n, in my	opinion, de	eath occured at the	time, date and	place, en	d due to the	ceuse(e) er	nd menner ee st	ated.
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER									onth, Day, Year)					
6688	2	30. NAME AND ADDRESS OF PERSON WH												,
Gary Fisher, M.D., 5530 Wisconsin Avenue, Chevy Chase, Marylan						nd 2	20815							
		8.8.00												1
		MAR 1 4 1995 Ju	his Davolson	Rardal	,									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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F VITAL RECORDS,
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PRATERIAND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	Emmediate Amer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	Flours and death with State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	i flem 28 is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
HOSPITAL OR ATTEN	HE FUNESAL DIFFECTOR	Brewn 72 hours after	DRTANT. If item 28
E	B	20	IMPC

	1 - STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
- 1	1. DECEDENT'S NAME (First, Middle, Last)	000-		1-0			DATE OF DEATH	V V	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5 SEX 6 AGE (In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS	19	ARCH 8	199	5 1:00 PH	
	213-48-0321	1 - M 2 OF	97 YRS.	ONTHS DAYS	HOURS MIN	. A	pril 23,	1897		
TOR	96. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital Baltimore City N/A RESIDENCE OF DECEMENT									
DIRECTOR	10a. STATE 10b. COUNT	timore	10c. CITY,	TOWN OR LOCAT	a/Fulle	erto	n	10d. INSIDE CITY LIMITS?		
FUNERAL I	100. STREET AND NUMBER 12 Virginia Aven	De. STREET AND NUMBER			ZIP CODE 21236	3		1 □ YES X (X)(NO 10g. CITIZEN OF WHAT COUNTRY? USA		
UNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DEC	ENDENT OF HIS	PANIC O	RIGIN? (Specify Yea		I. RACE — American Indian,	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, spe	2 NO Spe	dcan, Pu	arto Rican, etc.)		Specify: White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S US (Give kind of world) life. Do NOT use	rk done during mo.	ON st of working		16b. KIND OF BUS	INESS/INDUS	STRY	
MPL	Elementary/Secondary (0-12) 5th grade	College (1-4 or 5 +)	Sewing &	Sales			Chapman	's Awr	nings	
	17. FATHER'S NAME (First, Middle, Last)	man					First, Middle, Maiden . Schulz	Sumame)		
TO BE	19a. INFORMANT'S NAME (Type/Print)						Number, City or Town			
	Mr. A. J. Stritz		PLACE AND DATE OF			. Lo	ng Green		21U92	
	1 Neurial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)		ardens of			гу 3	/11/95 B	altimo	ore, Md.	
	21. SIGNATURE OF FUNERAL SERVICE LIC			22. NAME AN	D ACCRESS OF	FACILIT ETal	Y Home			
		revel Thos					Baltimo			
	23. PART I. Enter the diseases, or cahock, or heart fellure. IMMEDIATE CAUSE (Final	complications that caused List only one cause on as	tha daath. Do no ich iina.	t antar tha mo	da of dying, a	uch as	cardiac or respin	ratory arraa	Approximata Interval Batween Onset and Daath	
	disease or condition resulting in death)	· PULMO	MAR >	E	DEI	YA	1		24 1/5	
N	Sequantially flat conditions,	CONGES	STIVE	HEA	RT	FI	AILUR	'E	CHRONEC	
CATIC	if any, leading to immediata cause. Entar UNDERLYING	CORONA	CONSEQUENCE OF):	RTER	2 Y 9	7	SFA	SF	CHRONIC	
CERTIFICATION	CAUSE (Disesse or Injury that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):						51117-1-20	
	PART ii. Other significant condition	s contributing to death by	it not requiting to	the underlying	. cours ofuse	In Don	1 1			
ICAL		a contributing to death be	at not rauditing in	the underlying	cause given	in Part	1. 24a. WAS AN PERFOR	MEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEC							1	2110	DF DEATH?	
AN:	DID TOBACCO USE CONTI		F DEATH YES		UNCERTA	AIN [
SICI	EXAMINER?	HOSPITAL:		OTHER: Nursing Home	s 5 Realdens	a 6 🗆	Other (Snecity)			
PHYSICIAN: MEDIC	27. MANNER OF OEATH 1 Natural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJU	URY AT		. OEŞCRIBE HOW IN	JURY OCCUP	REO	
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY building, etc. (Speci	— At home, farm, stri	et, factory, office		281.	LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,	
E	4 Homicide datarmined									
Description of the basis of axamination and/or investigation, in my opinion, death occured at the time.										
ш	29b. SIGNATURE AND TITLE OF CERTIFIER		4		29c. LICENSE N				IGNED (Month, Day, Year)	
TO B	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	TH (ITEM 27) (Type P)	P-06	06	54	MA	1RCH 9th, 95	
	HAZEM AL-1	ANDARY	G-00,		YARI'	TAI	V HOSP.	TTAL	/	
	MAR 1 4 1995	32. REGISTRAR'S SONA	dell.							

→BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. ITEMS: 5. & 9b, PER F.H. FILM G-722 4/13/95 t.t

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALT CERTIFICATE OF DEA	H AND MENT	AL HYGIEN	E				
1	1. DECEDENT'S NAME (First, Middle, Lest)		TE OF DEATH	M MEAN	3. TIME OF DEATH			
	Gertrude Marie Schroeder		March 11,1995					
	MONTHS DAYS HOUR		TE OF BIRTH onth, Day, Year)	8. BIR Cou	THPLACE (State or Foreign			
	215-28-4891 1 N 2 NF 85 YRS.	Sep	t.17,19		land			
œ	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCA 1	ATION OF DEATH		9c. COUNTY OF	DEATH			
TO	Augusburg Lutheran Home BALIIMOR	E		Baltimo	ore			
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY			
ā	Maryland Baltimore Baltimore	,			LIMITS?			
FUNERAL	106. STREET AND NUMBER			10g. CITIZEN OF	WHAT COUNTRY?			
NE	6811 Campfield Road Room 265 212			U.S.A.				
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT 14. Never Merried 15. WAS DECEDENT 16. Yes 17. WAS DECEDENT 18. Yes 19. WAS DECEDENT 19. WAS	T OF HISPANIC ORIG	GIN? (Specify Yes o Rican, etc.)	Ble	CE — American Indian, ck, White, etc.			
BY	3 ₩ Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 ₩ N		, , , , , , , , , , , , , , , , , , , ,	Spe	White			
8	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION	1	5b. KIND OF BUS	INESS/INDUSTRY	WILLEE			
<u>H</u>	(Specify only highest grade completed) (Give kind of work done during most of wo life. Do NOT use retired.) (Give kind of work done during most of wo life. Do NOT use retired.)	rking						
APL	8th Grade Home Maker		OWA	1 Ho	ome			
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 18. MG	OTHER'S NAME (Firs	, Middle, Meiden					
BE (ertrude		Muel]	er			
2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Numi							
	Carol Marie Miksa 366 Winged Foot	Drive,Wes						
	20e. METHOD OF DISPOSITION 1 V Suriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place)	D/	TE 20c. LOC	ATION — City or	Town, State			
	1 N Burlel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) □ Immanuel Lutheran Cer 21. SIGNATURE OF FUNERAL SERVICE LICENSEE □ 22. NAME AND ADDI	metery 3	/14 Balı	timore,M	laryland			
	V TILL I I			l5 Belai				
	John C. 1				Md21206			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of a hock, or heart feilure. Liet only one cause on each line.	dying, such aa ca	rdiac or reepir	retory arrest,	Approximate interval Between			
	IMMEDIATE CAUSE (Fine) disease or condition	-1			Onaet and Death			
-	disease or condition	ch			sulle			
_	DUE TO (ON AS A CONSEQUENCE OF):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):							
S	cause. Enter UNDERLYING CAUSE (Disease or Injury							
E	thet initieted events DUE TO (OR AS A CONSEQUENCE OF):							
H	resulting in death) LAST							
AL C	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse	e given in Part i.	24a. WAS AN A	WITOPSY 24	b. WERE AUTOPSY FINDINGS			
S			PERFORM	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
E I			1 🗍 YES 2	LINO	OF DEATH?			
= =	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO E UN	ICERTAIN [1 YES 2 NO			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
YSI	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Outraing Home 5	Residence 8 - Oti	ner (Specify)					
H	27. MANNER OF DEATH 280. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK?	28d, D	EŞCRIBE HOW IN	JURY OCCURED				
B	2 Accident Investigation M 1 YES 2	□ NO						
- 11	3 . Suicide 8 Could not be determined 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify)	281, LC	CATION (Street or y or Town, State)	nd Number or Rural	Floute Number,			
E	An organization							
COMPLETED	29e. CERTIFIER (Check only one) One) PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place.							
8	MEDICAL EXAMINER: On the beats of examination emifor investigation, in my opinion, death occ	cured at the time, da	ta end place, end	due to the cause	(e) and manner ee stated.			
8	296, SIGNESTONE AND TITLE OF CESTURES	CENSE NUMBER		29d. DATE SIGNE	D (Month, Day, Year)			
2	20 NAME AND ADDRESS OF RESON WILL COMPLETED	128/	2	MARC	613 1985			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HIRO LD B, BJB AND 7220 PARICE	Heite	1 21	205				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) HACLUS B, BUSS AND 7220 PARSE (Regth 3520) 31. DATE FIRED MOORE, DOGS JULY 321 EGISTAR'S ENAMED.							

NA TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.

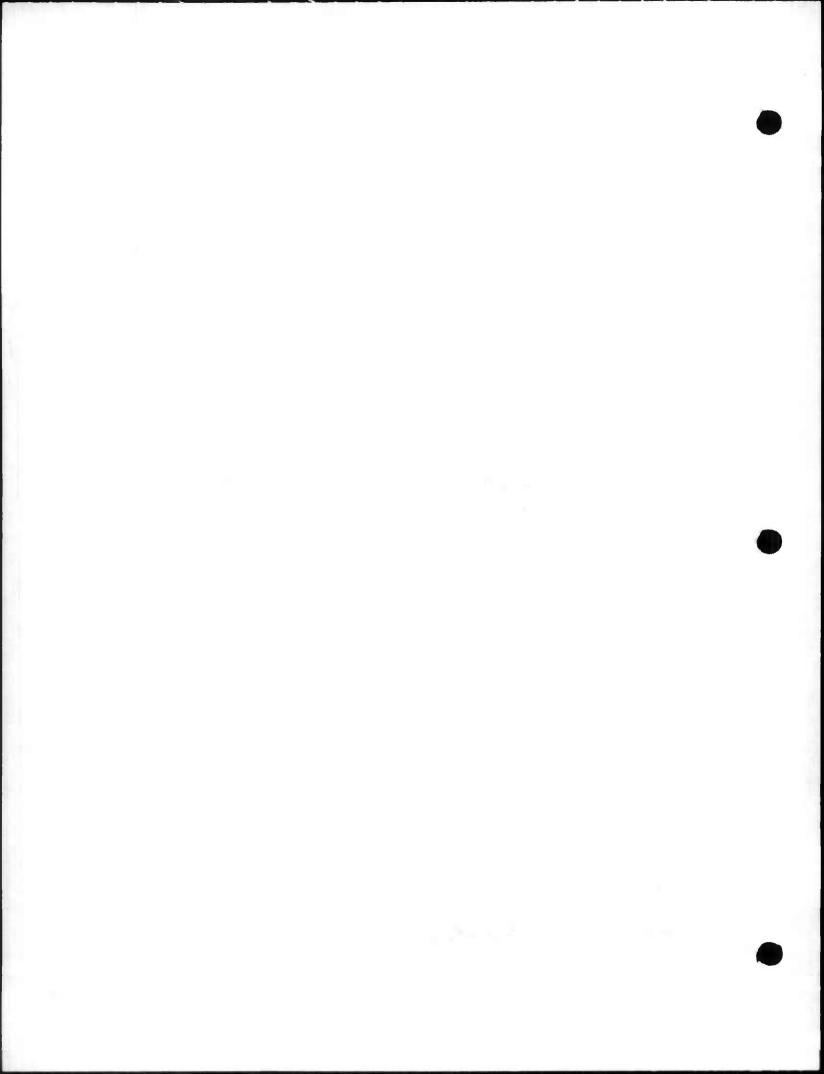
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

	1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H			YGIENE EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH		3. TIME OF DEATH
	Steve	Toledo	o, Sr.			MONTH	1 1	95	11:11 Pw
	The state of the s			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	IRTH (Mar)	8. BIRTI	IPLACE (State or Foreign
		216-16-2528 12 M 2 □ F 81 YAS. M					1,1913	Sp	ain
œ	9a. FACILITY NAME (If not institution, give street				R LOCATION OF D			UNTY OF D	EATH
DIRECTOR	Bayview Medical	Center		Baltim	ore, Ma	arylan	d -		
EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION				10d. INSIDE CITY
	Maryland Balt	imore		Eastp	oint				LIMITS? 1 YES 2XXNO
AL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CI	TIZEN OF	WHAT COUNTRY?
FUNERAL	7614 Gough Stre				21224		U	J.S.	Α.
F	11. MARITAL STATUS 1 Never Married 25 Married	12. WAS DECEDENT EVER IN FORCES? TYPES	2 NO	It was one	ENDENT OF HISPAI			14. RACI Blac	E — American Indian, k, Whita, etc.
B≺		IF YES, GIVE WAR OR DAT Ierchant Ma	rines II	1 TYES	2 NO Specif		•	Spec	"White
	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S US	SUAL OCCUPATIO	N	16b. KIND	OF BUSINESS/IN	DUSTRY	WIIICC
Ħ	(Specify only highest grade co	College (1-4 or 5+)	life. Do NOT use	rk done during mos retired.)	st of working				
MPI	12		Mech	anic		Ste	eel Mil	1	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle	, Maiden Surname)		
8	Damso Toledo	<u> </u>					Yugo		
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural				
	Anna M. Toledo 7614 Gough S								
	XXBurial 2 Cremation 3 Remove	al from Stata ceme	PLACE AND DATE OF tery, crematory or othe CYEC HES	r place)	3/1	5/95 1	20c. LOCATION -		
- 1	21, SIGNATURE OF PUNERAL SERVICE LICEN		cred nea				Baltimo	ore,	Maryland
1	(been 7/	Sunglein	-der		ZINSKI				
_	23. PART I. Enter the diseases, or con		the death De not	14070	old Eas	tern A	ve.Balt	t., M	D. 21221
	interval Between IMMEDIATE CAUSE (Final disease or condition resulting in death) Massive Cerebrovascular Accident With Hemorrhage 2 Days								
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
AL C	PART II. Other aignificent conditions	contributing to deeth bu	t not reculting in	the underlying	ceuse given in	Part I. 24a.	WAS AN AUTOPSY	24b	WERE AUTOPSY FINDINGS
Š	Hypertension, (Coronary A	rtery D	isease			PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?
PHYSICIAN: MEDIC									1 YES 2 NO
ż	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAIL	N 🗗			
호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF OEATH	(Check only one)					
XS	1 YES 2 NO	© ER/Outper	tient 3 DOA 4	☐ Nursing Home	5 - Residence				
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME (Y WO	RK?	28d. OEŞCRIBI	E HOW INJURY OC	CUREO	
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY -	- At home form etc		ES 2 NO	201 1 0017101			
TED	4 Homicide 6 Could not be determined	building, atc. (Specifi	y)	rei, rectory, office		City or Tow	(Street and Numbern, State)	or Hurai F	toute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) one) 2 🗆 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and								
ш	295 SIGNATURE AND TITLE OF GENTIFIER				29c. LICENSE NUI				(Month, Day, Year)
00	Jeremy Kil	MP			95040)	▶3	3/13	195
5	Jeweny Rich	Johns H	1	Hospita			9. Baltin		MD 21287
	31. WAR 1 1995 Ja	32. GISTAR'S NA	2.4			3			

DIVISION OF VITAL RECORDS, P.O. BOX 68760



DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

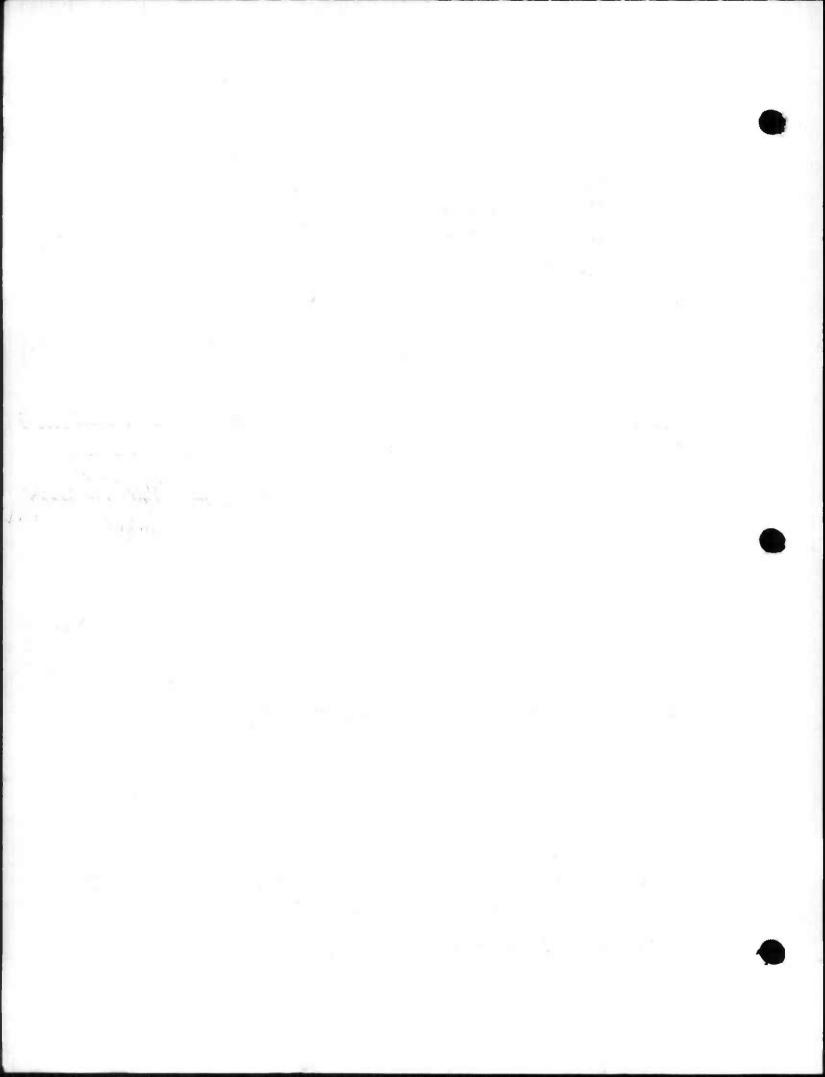
100	1. DECEDENT'S NAME (First, Middle, Last)								ned. No		
	Catherine		mpson						March 10	1995	3. TIME OF DEATH 2:50 P
	4. SOCIAL SECURITY NUMBER 212 36 8770	5. SEX 1 M 2 25 F	6. AGE (In yrs. 92	lest birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH	1902	BIRTHPLACE (State or Foreign Caunty) Maryland
	9a. FACILITY NAME (If not institution, give			<u> </u>	9b. CITY		OR LOCATI			9c. COUNT	Y OF DEATH
CTOR	Ivy Hall Ger	iatric Ce	nter			Midd	dle F	iver			Baltimore
DIREC	10a. STATE 10b. COUNT	Baltimore		10c. CIT	Y, TOWN		TION Sex				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER					10	I. ZIP COD			10g. CITIZE	1 YES 2 KNO
FUNERAL	8 Edgewater	Terrace					2	1221			USA
BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	ARMED		If yes, sp	CENDENT Concepts Cube	n, Maxicai	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No-	Black, White, etc. Specify: White
9	15. DECEDENT'S EDU (Specify only highest grade	JCATION	16a.	DECEDENT'S	USUAL O	CCUPATION	ON		16b. KIND OF BU	ISINESS/INOUS	TRY
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 -	-)	(Give kind of ille. Do NOT u Hou	work done se retired.) ISEWI		ost of working	ng .		Home	
Ŏ.	17. FATHER'S NAME (First, Middle, Last)					_	16. MOT	HER'S NA	ME (First, Middle, Maider		
ш	0	ick							ret Schn		
10 B	John Thompson			19b. MAILING	ADDRES	S (Street	and Number	or Rural R	Courte Number, City or Too	vn, State, Zip Co	
	20a, METHOD OF DISPOSITION		202 01 40	E AND DATE				ce	Baltimore		21221
	1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	noval from State	Sacr	ed of He	(becores)	of i	_{ame or} Jesus	Cem	DATE 20c. LO		or Town, State
- 1	21. SIGNATURE GE/FUNERAL SERVICE LI	CHRISEE	1		22.	NAME A	NO ADDRE	SS OF FAC	SILITY		1010 004, 120
	1	And	My						Funeral H		
	23. PART I. Enter the diseases, or	complications that	caused the	death. Do i	not enter	the mo	de of dvi	ng. auch	Ave. B	altumo	re, MD 21221
	shock, or heart failure.	List only one cau	se on each il	ne.			,		. and curious or resp	matory arrea	interval Betwee
ı		ASPI OUE TO	RAT	CON	7	PI	NAC	in	ONIA		10 days
	reading in death)	DUE TO	OR AS A CONS	SEQUENCE O	F):		7 0		141711	0+	1000013
Z O	Sequentially list conditions,	OERE	EBR.	AL	E	MR	50 L	15 M	N WITH	101	EGIA 3WK
CATION	if any, leading to immediate cause. Enter UNDERLYING	At	TA P	EUUENCE O	h	11	at	100	1461	1110	84/4
RTIFIC	CAUSE (Disease or Injury that initiated events	C. DUE TO	OR AS A CORS	EOUENCE O	F):	10		101	1		2 150
FF	resulting in death) LAST	d									
E	PART ii. Other aignificant condition	na contributing to	death but no	resuiting	in the un	derivin	a cause c	iven in I	Part i. 24s. WAS AN	ALITOREY	24b. WERE AUTOPSY FINDINGS
DICAL	ALZ HE	IMER		DIS					PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
# II	PEPTIC	ulc	ER	D	15	65TA	-86		1 🗀 YES	NO NO	OF DEATH?
AN: P	DID TOBACCO USE CONT							ERTAIN	IXIX		TES 270 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF DEA							
YSICI	1 TYES 2 NO	1 Inpetient 2	ER/Outpetient	3 🗆 DOA	4 Whun		e 5 □ Re	sidenca (B Other (Specify)		
PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, De	INJURY ly, Year)	28b. TIM	E OF URY		PRK?		28d. DEŞCRIBE HOW	NJURY OCCUP	EO
à	2 Accident Investigation	28a PLACE OF	F INJURY — At	home form	MI I		YES 2	NO			
ETED	4 Homicide 8 Could not be datarmined	building,	etc. (Specify)	none, latti,	ariout, ract	ory, orner	•	- 1	281. LOCATION (Street City or Town, State,	and Number or	Hursi Houte Number,
COMPLE	29e. CERTIFIER (Check only one)										
8	29b. SIGNATURE AND TITLE OF CERTIFIES		amination and/o	r Investigatio	n, in my o	pinion, d				id due to the c	suse(s) and manner as stated.
出	Bu VIV	-00			m.	0	D	NSE NUM	20 0		GNED (Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH (IT	EM 27) (Туре,	Print)	_		1 /	0 0015	2	10-13
	30. NAME AND ADDRESS OF PERSON WHE	1. M.D.	8027	- B	EL	A11	2/4	079	D) ISHL	ind-	217.76
100											Case to the year of

BALTIMORE, MARYLAND 21215-0020

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uires that the death certificate be executed within a nours after death. Page 6 may be retained by the hospital or attending physician.	signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	Health and Mental Hygiene prior to burial, cremation, or removal.	
iires that	signed by	Health and	
law requ	las been	Dept. of h	
IAN: The	rtificate h	ne State	
3 PHYSIC	er this ce	vithin 72 hours after death with the State Dept. of	
TENOING PH	RECTOR: After	after deat	
OSPITAL OR AT	IL DIREC	2 hours	
HOSPIT.	FUNERA	within 7	

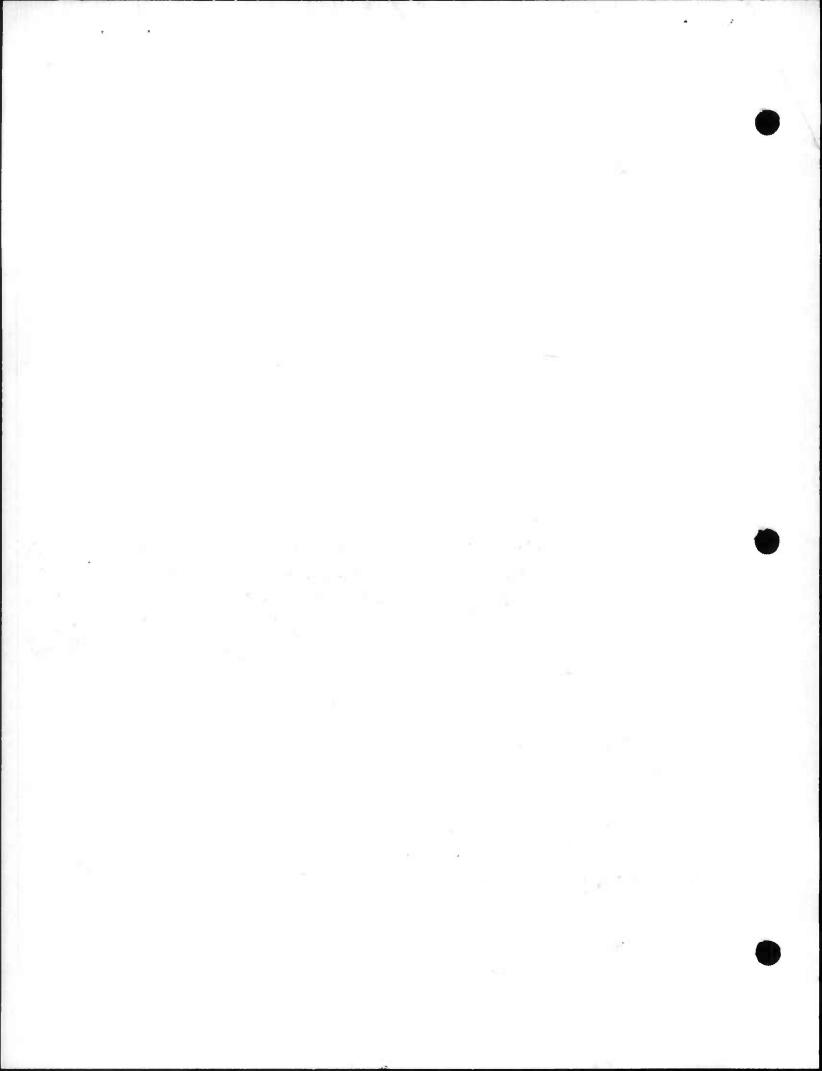
	1 - FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last, JOSEPHINE	Thrower			2. DATE OF DEATH MONTH 3 DAY //	95 3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 214-20-7524	5. SEX 6. AGE	(In yrs. lest birthday) IF (MON	MOER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MIN.	7. DATE OF BIRTH (Month) Clay Yes, 19	8. BIRTHPLACE (State or Foreign			
OR	9a. FACILITY NAME (If not institution, give	street and number)	96.	CITY, TOWN OR LOCATION OF D	EATH Sc. COU	OF ARMADEL			
DIRECTOR	10a. STATE 10b. COUN	ADUADE)	10c. CITY, TO	WN OR LOCATION		10d. INSIDE CITY LIMITS?			
	100. STREET AND NUMBER	AND RIK		101. ZIP CODE	10g. CIT	1 VES 2 NO			
FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 NO	If yes, specify Cuban, Maxic		14. RACE — American Indian, Black, Whita, atc.			
ED BY	3 Widowed 4 Divorced 15. DECEDENT'S ED (Specify only highest grace)	UCATION	16a. DECEDENT'S USU	1 YES 2 NO Special NO	16b. KIND OF BUSINESS/IN	BLACK			
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	He. Do NOT use ret	None during most of working red.) RESS	CLOTAL	ING			
ш	17. FATHER'S NAME (First, Middle, Last) JOHN PRUS	TER	9: 1	16. MOTHER'S NA	AME (First, Middle, Majden Surname)	2			
TO B	199. INFORMANT'S NAME (Types of the Control of the	VSIER	207/	RESS (Street and Number or Rural	Agine Number, City or Town, State, Zi	E/Chim 21225			
	20s METHOD OF DISPOSITION 1 Surface 2 Cramation 3 Red 4 Donation 5 Other (Specify)	noval from State cen	PLACE AND DATE OF DI	SPOSITION (Name of lace)	3/16/95 AVOTOR	- City or Town, State			
	21. SIGNATURE OF SUNFRAL SERVICE L	CENGER		22. WAME AND ADDRESS OF THE	RENTINERO/	Alma PAI			
	23. PART & Enter the discoses, or shock, or heart fellure IMMEDIATE CAUSE (Finel	complications that caused. List only one cause on e	d the deeth. Do not e ech line.	inter the mode of dying, such	ch sa cerdiec or respiratory as	rrest, Approximete interval Between Onset and Death			
	disease of condition a. ASCVD DUE TO (OR AS A CONSEQUENCE OF):								
LION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events DUE TO (OR AS A CONSEQUENCE OF):								
AL CER	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
MEDICA					PERFORMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
N. M	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF D	EATH YES NO		1 TES 2 NO			
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMPLER? 1 YES 2 NO	HOSPITAL: 1 Inputient 2 ER/Outp	ortlant 3 DOA 4	26, PLACE OF DEATH (C) HER: Nursing Home 5 Residence					
Y PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF		26d. DESCRIBE HOW INJURY OC	CCURED			
TED BY	3 C Suidide	Accident Investigation Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number, hullding, atc. (Specific)							
COMPLETED					s to the cause(s) and menner as ata time, data and place, and dus to t				
BE CC	296. SIGNATURE IND TITLE OF CERTIFIE			29c. LICENSE NU		TE SIGNED (Month, Dgy, Year)			
7	30. HAME AND MODRETS OF PERSON Y	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print		V10	711111			
	31. DATE PILED (MONTH, Day, New)	32. REGISTRAR'S SIGN	ATURE COLLEGE	·U					



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	L URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages I have after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within control and the death. Page 6 may be retained by the hospital or attending physician.	L URECTOR: After this certificate has been signed by the attending physician and completely filled in by the i hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or remonal.

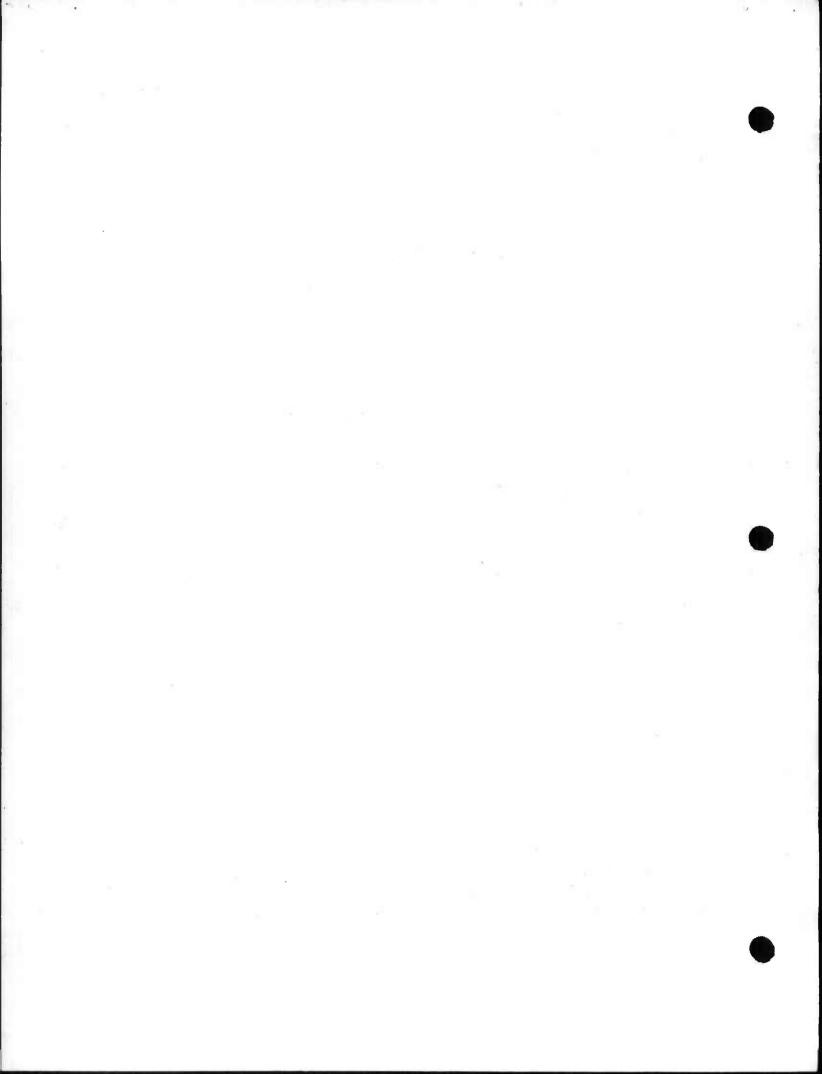
TO THE HOSPITAL OR AITENDING PHYSICIAN; The law reg TO THE FUNERAL DIRECTOR: After this certificate has been

1. DECEDENT'S NAME (First, Middle, Last) Patrick			Тто	tor					YEAR	3. TIME OF DEATH
										12.55
211-50-4452	1 XM 2 - F	6. AGE (In yrs. I	yrs.	MONTHS DAYS	HOURS	R 24 HRS.	(Month Day Venr)			PLACE (State or Fore V) NSYLVANI
Constant Pales Will I Constant										
	1		10c CIT	Y TOWN OR LOCAT	ION					ANA IMPIOS OUTV
	LTIMORE		1.55. 6.1			Y				10d. INSIDE CITY LIMITS? 1 YES 2 X No
	14010 Cub	oa Rd.		101	. ZIP COD	-	.030			HAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	FDRCES?	FDRCES? 1 YES 2 NO If yes, specify Cuban, Mexic				en, Mexican,	NIC ORIGIN? (Specify Yes or No— Black, White, etc.) 7: Specify:			, White, etc.
15. DECEDENT'S EDUCATION (Specify only highest grade completed) ElementarySecondary (0-12) College (1-4 or 5 +) If 6. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)						ing	WHITE			WIIII
4-	5+	·	Att							
17. FATNER'S NAME (First, Middle, Last)		18. MOTNER'S NAME (First, Middle, Maiden Surname)								
George Edward Tranter										
The state of the s										
20a. METNOD OF DISPOSITION			AND DATE	OF DISPOSITION (Na		, man	DATE 20c.			
4 Donation S Other (Specify)	remator				atonsv	/ille	, MD			
New wood	of Alex	dur)	Lemmo	on Fu	uneral	. Home			
		at caused the d	leath. Do n	10 W	. Pac	donia	Rd., Ti	monium	n,MD	
immediate cause (Final disease or condition	ROLLO	on each lin		~					408	Approximation of the control of the
	DO DUE TO	LATTO O	TOUENCE OF	P):			-1	V	an C	71
if any, isading to immediate	D DUE TO	(OR AS A CONST	ONEMEE OF	Senie	0100	OKO	esta.	DA	M	en sila.
CAUSE (Disease or injury								11/10		
resulting in desth) LAST							~~~	all	an	30
PART II. Other significant condition	a contributing to	death but not	resulting i	in the underlying	cause	given in Pe	TE ZEL WAS		24b	WE'RE AUTOPSY FIND
										MASLABLE PRIOR TO COMPLETION OF CALL OF DEATH?
DID 700 1000 1100 001 001				_ ^	_					1 - YES 2 - NO
	RIBUTE TO CA				MINIC	ERTAIN				
EXAMINER?	NOSPITAL:		OTHER:							
27. MANNER OF DEATH 1 Planting 5 Panding	28s. DATE OF	WILLIAM	28b. Tiles	E OF 28c. INJ	URY AT	2		W INJURY OC	CURED	
Accident Investigation Could not be determined	28s. PLACE C building.	F INJURY — At h ets. (Specify)	ome, farm, e						sute Number	
2 MEDICAL EXAMINE	R: On the beals of e	xamination and/or	Investigation	n, in my opinion, d	eath occu	red at the tim	e, date and place,	and due to th	na cause(a)	and manner as stat
Company	X	Ocai			Dec. LICI	ENSE HUMBE	78C	29d. DAR	310	39
					Balt	M	D 21208	(Suit	e 30	0)
31. DATE FILED (Month, Day, Year)		R'S SIGNATURE				- , ,		,5416		- /
	Patrick 4. SOCIAL SECURITY NUMBER 211-50-4452 8a. FACILITY NAME (If not institution, give a Greater Balto RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MARYLAND BA 10a. STREET AND NUMBER 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 4. T. FATNER'S NAME (First, Middle, Last) George Edward Tra 19a. INFORMANT'S NAME (Type/Print) George Vranian 20a. METNOD OF DISPOSITION 11 Duriel 2 Coremetton 3 Rem 4 Donation 5 Other Specify 11. SIGNATURE of THERA SERVICE LK 23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) DID TOBACCO USE CONTINE Accident Suidolfie Counts not be determined. 2 Suidolfie Counts not be determined. 2 MARINER OF DEATH 1 Natural Suidolfie Counts not be determined. 2 MEDICAL EXAMINE 20a. CERTIFIER Check only MEDICAL EXAMINE 20b. MAME AND ADDRESS OF PERSON WH. MIChael L. Leving Medical Examined.	Patrick 4. SOCIAL SECURITY NUMBER 211-50-4452 5. SEX 211-50-4452 1	Patrick 4. SOCIAL SECURITY NUMBER 211-50-4452 5. SEX 211-50-4452 6. AGE (In yrs. In 2	Patrick Security Number 211-50-4452 1	Patrick 4. SOCAL SECURITY NUMBER 211-50-4452 5. SEX 211-50-4452 6. AGE (in yrs. law behiddey) Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center TOWSO: Greater Balto. Medical Center 100. CITY. TOWN OR LOCK TOWSO: Greater Balto. Medical Center 101. Was December Balto. Medical Center 102. Medical Center Balto. Medical Center 103. Widowed 4 Discorder 104. DECEMBER'S LIFE BALTONER 105. CITY. TOWN OR LOCK 105. CITY. TOWN OR LOCK 106. CITY. TOWN OR LOCK 107. Was December Balto. Medical Center 108. CITY TOWN OR LOCK 109. Was December Balto. Medical Center 109. Widowed 4 Discorder Baltoner 109. Widowed 4 Discorder Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. College (1-4 or 6 +) 109. Malling Aboress Greater 109. Was December Baltoner 109. Malling Aboress Greater 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center Baltoner 109. Medical Center	Patrick	Patrick 4. SOCIAL SECURITY NUMBER 211-50-4452 5. SEX 211-50-4455 5. SEX 211-50-0455 6. AGE (in yrx. land Distribution. Days 1 Houses 1 YEAR. 1 HOURS 1 WINC. 21 TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION OF DEAT TOWN OR LOCATION	PARTICLE 4. SOCIAL SECURITY NUMBER 5. SEX 1. CRE 2 F S. AGE (FO) FILE AS CONTROLOGY SPECIAL TEAM FUNCES 31 MSL AGE (FO) FILE AS CONTROLOGY SOCIAL	PART ICK **BOGAL SECURITY NUMBER **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY SECURITION **SOCIAL SECURITY	Patrick 1. BOOM. SECONTY NUMBER 1. SEX: S. AGE (in yr. in a drawley) Sewer 1 year Property



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: if Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	ath c	tendi	al Hy	0
	Je de	the at	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Juny
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT			MENTA	L HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF DEATH			3. TIME OF DEA	TH
	Larry	Thorpe					MONT	H D		EAR	1100	ан
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday			IF UNDER 24 HRS.	7. DATE	OF BIRTH		BIRTH	PLACE (State or F	Foreign
- 31	212-56-598	212-54-5994 BM20F 44				HOURS MIN.		th, Day, Year) -8-50		Country	MD	
	ea. FACILITY NAME (If not institution, give st			9b. CITY, 1	TOWN OR	LOCATION OF DE		0. 50	9c. COUNTY			
DIRECTOR	Mercy Med	lical Cont	ev	В	BALT	IMORE	CIT	Y	N?	A		
EG	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. C	ITY, TOWN OR							10d. INSIDE CIT	_
E I	MD	N/A				E CITY	-			- 1	LIMITS?	
	10e. STREET AND NUMBER				10f, Z	IP CODE			10a, CITIZEI		HAT COUNTRY?	NO
ER/	1829 SAINT PA	UL STREET	APT 3	01		212	18		U.S			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	N U.S. ARMED	13, W	AS DECEN	DENT OF HISPAN	IIC ORIGII	N? (Specify Yee		RACE	— American Ind	llen.
	1X Never Married 2 Merried	FORCES? 1 X YES		H 1	yee, speci	NO Specifi	n, Puarto	Ricen, etc.)		Black Specif	, White, etc.	
) BY	3 Widowed 4 Divorced	UNKNOWN								B	LACK	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT' (Give kind or	f work done du	CUPATION uring most	of working	16b	. KIND OF BU	SINESS/INDUS	TRY		
ا ۳	Elementary/Secondary (0-12)	College (1-4 or 5+)	iffe. Do NOT	use retired.) EMPLO	VED			N/	7\			
Š	17. FATHER'S NAME (First, Middle, Last)	N/A	ON	EMPLO				•				
		HORPE			- 1	18. MOTHER'S NA DOROTH			ARRIS	1		
BE	19e. INFORMANT'S NAME (Type/Print)	HORLE	19h, MAIL IN	G ADDRESS /		Number or Rural I						
2	JEANETTE PAIGE		2104	BOON	VE S	T BALT	IMO	RE, M	D. 21	21	8	
	20e. METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of DATE 20c LOCATION — City of Town State											
	1X Burial 2 ☐ Cremation 3 ☐ Ramo 4 ☐ Donation 5 ☐ Other (Specify)		T ZION	CEME	ETER	Y	3/	11 LA	NSDOW	INE	, MD.	
	21. BIGNATURE OF FUNERAL SERVICE LIC	ENSEE	/			ADDRESS OF FA	OIL IT'V	ETTS			-	
	*Aprilalia	Vion	atti	11	129	N. CAR						13
	23. PART . Enter the diseases, or c	omplications that cause	d tha death. Do	- 1							Approxim	
	shock, or haart/fellura. I	lat only one cause on e	ach Ilna.			,				.,	Intarval E	Batween
	dia and a second dia an								d Death			
	a. Preumocystis Carinii preumonia Due to (or as a conscouence of):											
z		Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):										
입												
S	Susse. Enter UNDERLYING AUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
	that initisted evants resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE (OF): J	'							
CERTIFICATION		d										
AL	PART II. Other algolficant conditions	contributing to death b	ut not rasulting	In the und	derlying o	causa given in	Part I.	24s, WAS AN PERFOR			WERE AUTOPSY F	
								1 TES 2			AVAILABLE PRIOR COMPLETION OF OF DEATH?	
ME							_		7	1	1 YES 2	NO
PHYSICIAN: MEDIC												
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				CE OF DEATH (Ch	ock only or	ne)				
YSI	1 TYES 2 THO	1 Inpatient 2 - ER/Outp	patient 3 DOA	OTHER:		5 Residence	6 🗆 Othe	r (Specify)				
F	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TI	ME OF 2	28c. INJUR WORK		26d. DES	SCRIBE HOW II	NJURY OCCUP	IED	-	
à	1 Natural 5 Pending 2 Accident Investigation			М	1 YES	S 2 NO						
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, cify)	, street, factor	ry, office		281. LOC City	or Town, State)	and Number or	Rural Ro	oute Number,	
COMPLETED												
절		CIAN: To the best of my know										
g I		R: On the beels of axaminatio	n and/or investigat	lon, in my opi	inion, deat	th occured at the	time, date	and place, an	d due to the c	euse(e)	and menner as	stated.
BE	296. SIGNATURE AND TITLE OF CENTIFIED				2	19c. LICENSE NUN			29d. DATE S	IGNED	(Month, Day, Year)	
0	20 NAME AND ADDRESS OF THE	NV MAS				P068	54		P 3	5/7	145	
	30. NAME AND ADDRESS OF PERSON WHO				·				7			
		MD 22	S Gre	ene s	7	Baltim	الاسور	Md	212	21		
31. DATE FILE (M971). 4 1995 Julia 2 De 1851 1802 2 18 1804 2 18 1804 2												



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TOTAL THE INVIENDINGS that the beath certificate be executed which 24 hours are	plete	will it hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MITH Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be noti
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95 07693 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Anna Elizabeth Unkart 730 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH MONTHS DAYS HOURS 218-46-1181 1 M 2 X F 88 YRS June 7,1906 Kingsville,Md 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 428 Priestford Road DIRECTOR Churchville, Harford RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Churchville 1 TYES 2 X NO FUNERAL 10e STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 428 Priestford Road 21028 U.S.A. 11. MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a, DECEDENT'S USUAL OCCUPATION 16h. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Farmer 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) George Unkart Catherine Beyer BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Hilda A. Unkart 430 Priestford Road Churchville, Md. 21028 20a_METHOD OF DISPOSITION
1/1 ABurlai 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State "St":Paul" Lutheran Church Cem. 3/11/95 Kingsville, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home assa Co. 11750 Belair Road Kingsville Md. 21087 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximats shock, or heart failure. List only one cause on each line. intarysi Between **IMMEDIATE CAUSE (Final** Onset and Dasth disease or condition resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequantially list conditions, TO (OR AS A CONSEQUENCE OF If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 |-110 OF DEATH? Kry 77 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO D UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY 3 Suicide OMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIE 29c, LICENSE NUMBER SIGNED (Month, Day, Year)

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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30. NAME AND ADDRESS OF

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• BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

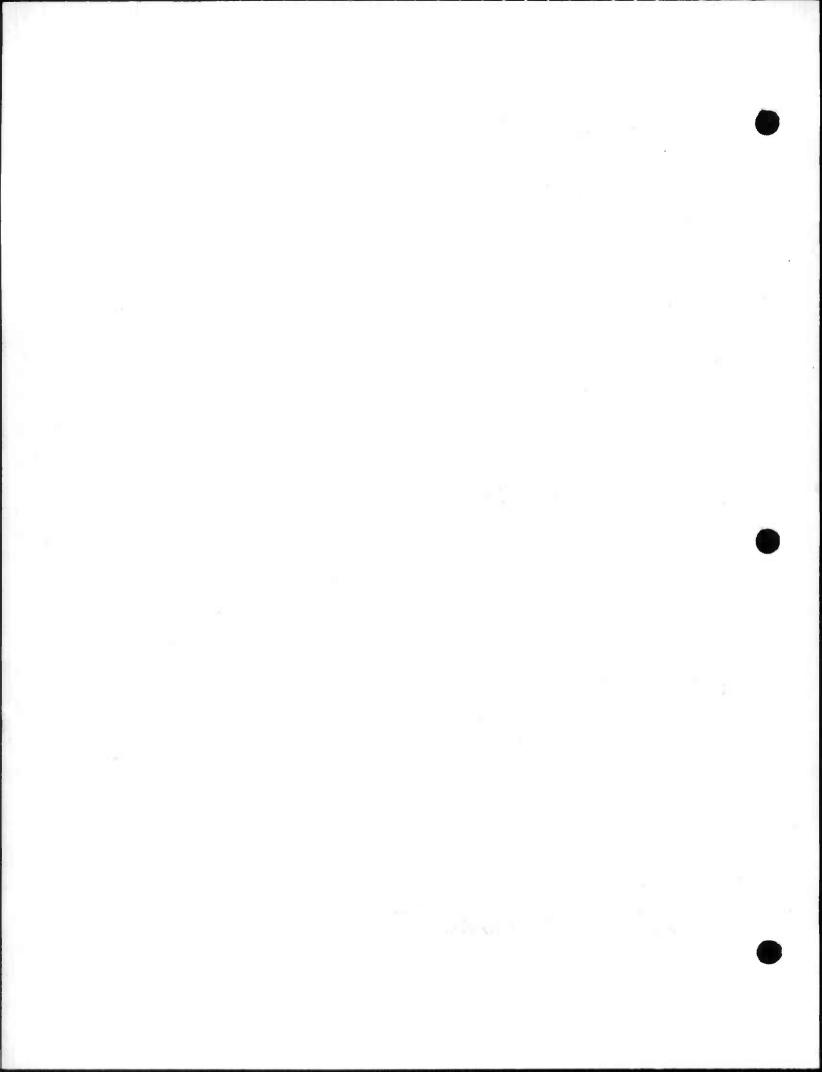
FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ATE OF DEATH	REG. NO.	,					
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATN		3. TIME OF DEATN				
	Virginia Kathleen Vargas			03-10-95	AY YEAR	1:00 p.m. m				
		in yrs. lest birthday) II	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH						
		MC	HITHS DAYS HOURS MIN.	(Month, Day, Year) 03-05-27	E. BIH Cou	THPLACE (State or Foreign ntry)				
	232 34 0433	68 YRS.		03-05-27	Wes	t Virginia				
	9a. FACILITY NAME (If not institution, give atreet and number)	9	D. CITY, TOWN OR LOCATION OF DE		9c. COUNTY OF					
18	3725 Stepping Stone Lane		Burtonsvil	Le	Mon	tgomery				
15	RESIDENCE OF DECEDENT									
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, 1	OWN OR LOCATION			10d. INSIDE CITY				
5	Maryland Montgomery	_	Burtonsvil	20.		1 YES XX NO				
1	10e. STREET AND NUMBER		10f. ZIP CODE		10a. CITIZEN OF	WHAT COUNTRY?				
FUNERAL	3725 Stepping Stone Lane		20866		us	1				
Z	11. MARITAL STATUS 12. WAS DECEDENT EVER IN	ILIS ADMED	13. WAS DECENDENT OF NISPAI	110 ODIONE M 4 - 4 -						
	1 Never Merried 2 Merried FORCES? 1 YES	2 NO	It yes, specify Cuben, Maxica	n, Puarto Rican, atc.)	Ble	CE — American Indian, ick, Whita, atc.				
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DA	TES	1 TYES 2 TYNO Specif	r:	Spe	white				
	15. DECEDENT'S EDUCATION	44- DEGENERATIO LIO	1							
	(Specify only highest grade completed)	(Give kind of work life. Do NOT use n	done during most of working	16b. KIND OF BUS	SINESS/INOUSTRY					
1 5	Elementary/Secondary (0-12) College (1-4 or 5+)		= 1 -1							
e ₹	9	Home	maker		Home					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Meiden	Surname)					
B a	William Underwood		Virgin	ia Cottle						
	19a, INFORMANT'S NAME (Type/Print)	19b. MAILING AD	ORESS (Street and Number or Rural	Route Number, City or Town	n, State, Zip Code)					
들은	Teresa Vargas Sevier	3725 S	tepping Stone	Lane. Burto	onsville	. MD 20866				
ě	20e. METHOD OF DISPOSITION 20h	PLACEANDDATEOF		OATE 20c. LO						
	1 Buriel 2 Cremation 3 Removal from State Cerm 4 Donation 5 Other (Specify)	stery, crematory or other	ashington Crem	2/11	CATION - City or	town, Stata				
5	21. SIGNATURE OF FUNERAL SETTICE LICENSEE	llimore-w	asnington crem	. 13/11 Lau	vier, ma	rykana				
Ē	A STATE OF THE STA		22. NAME AND ADDRESS OF FA	oility Frech	tuneral	Home, Inc.				
ex a	1 alc 0 00, 400 06,		7601 Sandy S	oring Road,	, Laurel	, MD 20707				
any injury, or other traumatic event, the medical examiner must be notified at once. DICAL CERTIFICATION TO BE COM	23. PART I/Enter the diseases, or complications that caused the death. Do not enter the mode of duling such as cardiac or resolveton expert.									
2	shock, or heart fallure. List only one cause on ea	Interval Between								
9	IMMEDIATE CAUSE (Final disease or condition resulting in death) Oue TO (OR AS A CONSEQUENCE OF): Oue TO (OR AS A CONSEQUENCE OF):									
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SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH								
	1 YES 2 NO 1 Inpatient 2 ER/Output		THER: Nursing Nome 5 Residence	8 Other (Specify)						
	27. MANNER OF OEATN 28s. DATE OF INJURY	28b. TIME O	F 28c. INJURY AT	28d. OEŞCRIBE HOW IN	NJURY OCCURED					
	1 Natural 5 Pending (Month, Day, Year)	INJURY	M 1 YES 2 NO							
BY	200 PLACE OF IM HUDY	— At home, term, street		281 LOCATION /Smell of	and Mumber on Russi	Doub Alumbas				
(LI) eq	4 Homicide 8 Could not be determined building, atc. (Speci	fy)		28t, LOCATION (Street a City or Town, State)	THE PROPERTY OF MUISE	roome reamber,				
E	200 CERTIFIED K									
≝ ਫੁ	29a. CERTIFIED (Check only CERTIFYING PHYSICIAN: To the best of my knowledge (Check only CERTIFYING PHYSICIAN: To the best of my knowledge)	edge, death occurred a	t the time, data and place, and due	to the cause(a) and man	ner as atated.					
D BE COMPLE	2 MEDICAL EXAMINER: On the beals of examination	and/or Investigation, is	n my opinion, death occured at the	time, date and place, and	d due to the cause	(a) and manner as stated.				
E 0	29h/SIGNATURE AND TITLE OF CENTIFIER		29c. DCENSE NUM		294. DATE SIGN					
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARCH UNE 2:42 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 213-14-4519 HOURS 1 🗌 M 2 💢 F 85 12-26-1909 Virginia Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Laurel Regional Hospital Laurel Prince George 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George Laurel permit. 1 - YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 16911 Melbourne Drive 20707 USA Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORION? (Specify Yes or NoIf yes, specify Cuban, Maxicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 🛛 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Rorabaugh notified at Ada Bibb 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Barbara V. Feagin 16911 Melbourne Drive Laurel. Maryland 20707 9 20a. METHOD OF DISPOSITION
1 (X Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must Gemetery, cremetory, or other place)
Meadowridge Memorial Park Donation 5 - Other (Specify) _ 3/9 Dorsey, Maryland examiner 21. SIGNATURE OF FUNERAL SURVICE UP 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. L has been signed by the attending physician and completely filled in by the 1 Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. Laurel. 20707 23. PART L'Enter the diseases, or complice ons that caused the death Do got siter the mode of dying, auch as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only interval Between IMMEDIATE CAUSE (Final Onset and Dasth disease or condition_ DAR-DINUMI resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL эпу 1 TES 2 NO OF DEATH? t - YES 2 - 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN IN PHYSICIAN: PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem DIRECTOR: After this certificate I hours after death with the State HOSPITAL: OTHER: I YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. Natural 5 Pending Investigation м 1 YES 2 NO BY ATTENDING 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 8 Could not be COMPLETED 4 Homicide 28 OR O 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, end due to the cause(a) end manner as stated. FUNERAL within 72 ? TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 15 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIED 29c. LICENSE NUMBER
04276 29d. DATE SIGNED (Month, Day, Year) BE 6/95 3 2 SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8317 Chen Lare MO Laurel



STATE REGISTRAR

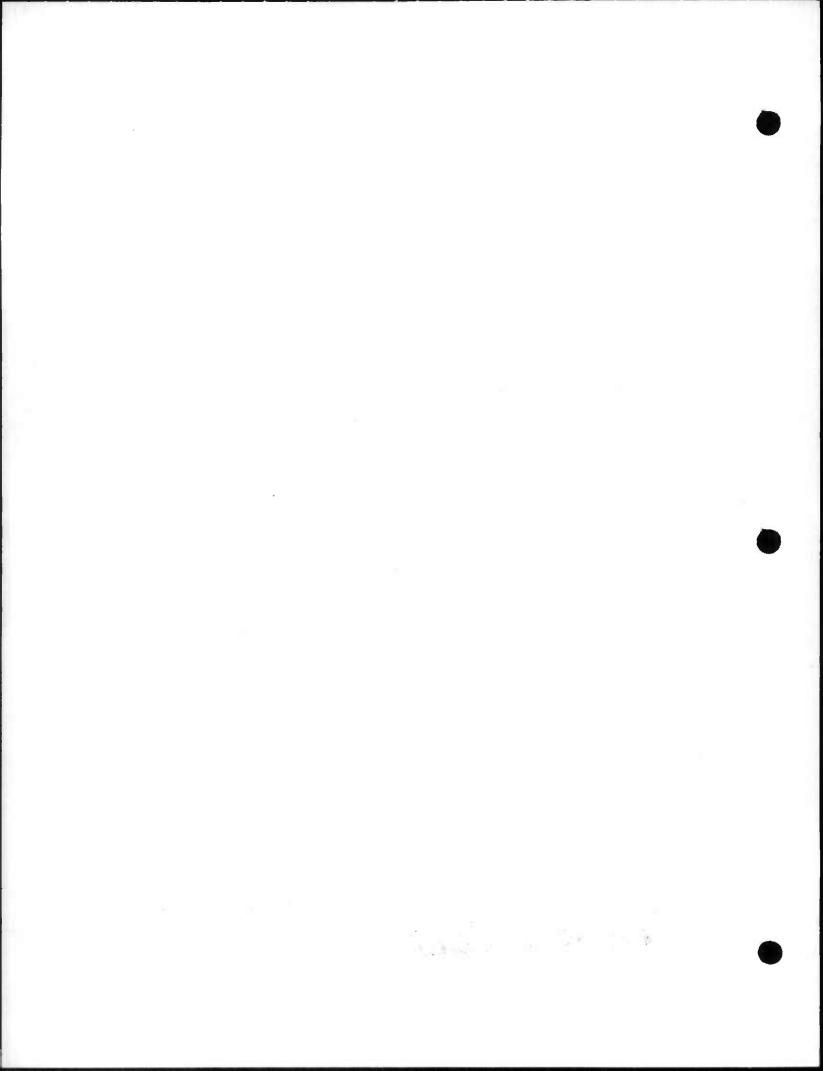
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR RITA C. VALENZIA MARCH 1995 10:00 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 TF DAYS HOURS 215-16-0703 DEC.8,1922 YRS. MARYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 402 S. SMALLWOOD STREET BALTIMORE BALTIMORE CITY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY BALTIMORE permit. 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 402 S. SMALLWOOD STREET be detached for use as the burial-transit 21223 U.S.A. retained by the hospital or attending physician 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puerio Rican, etc.)
1 YES 2X NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, alc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Married 2 XMarried BY 3 Widowed 4 Divorced Specify: WHITE ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8TH GRADE SEAMSTRESS COMFY'S MFG. COMPANY 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) (UNKNOWN) FITZPATRICK BE MARY NOONAN funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. FRANK C. VALENZIA 402 S. SMALLWOOD STREET - BALTIMORE, MD 20 9 20a. METHOD OF DISPOSITION
1 N Burlal 2 Cremellon 3 Removal from State Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must LOUDON PARK CEMETERY ☐ Donation 5 ☐ Other (Specify) ... 3/13 BALTIMORE examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY death. HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE, BALTIMORE, MD n and completely filled in by the to burial, cremation, or removal. 21229 hours after medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart initure. Liet only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death the disesse or condition metastatic colon cancer 10 months event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician I Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease Dr injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? been signed by the MEDICAL any 1 YES 2 NO OF DEATH? 1 YES 2 WHO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TO UNCERTAIN TO PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) the State HOSPITAL OTHER: 1 YES 2 NO ATTENDING PHYSICIAN: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) marked, 28c. INJURY AT this t 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO After t death BY 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 99 ETED. 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: 4 Homicide 28 determined DR ltem. 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. COMPL FUNERAL within 72 h HOSPITAL -TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II 2 __ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Ottan 40850 ▶ 3.10.95 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. YVONNE OTTAVIANO - ONCOLOGY DEPT - 900 CATON AVENUE - BALTIMORE, MD 21229 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

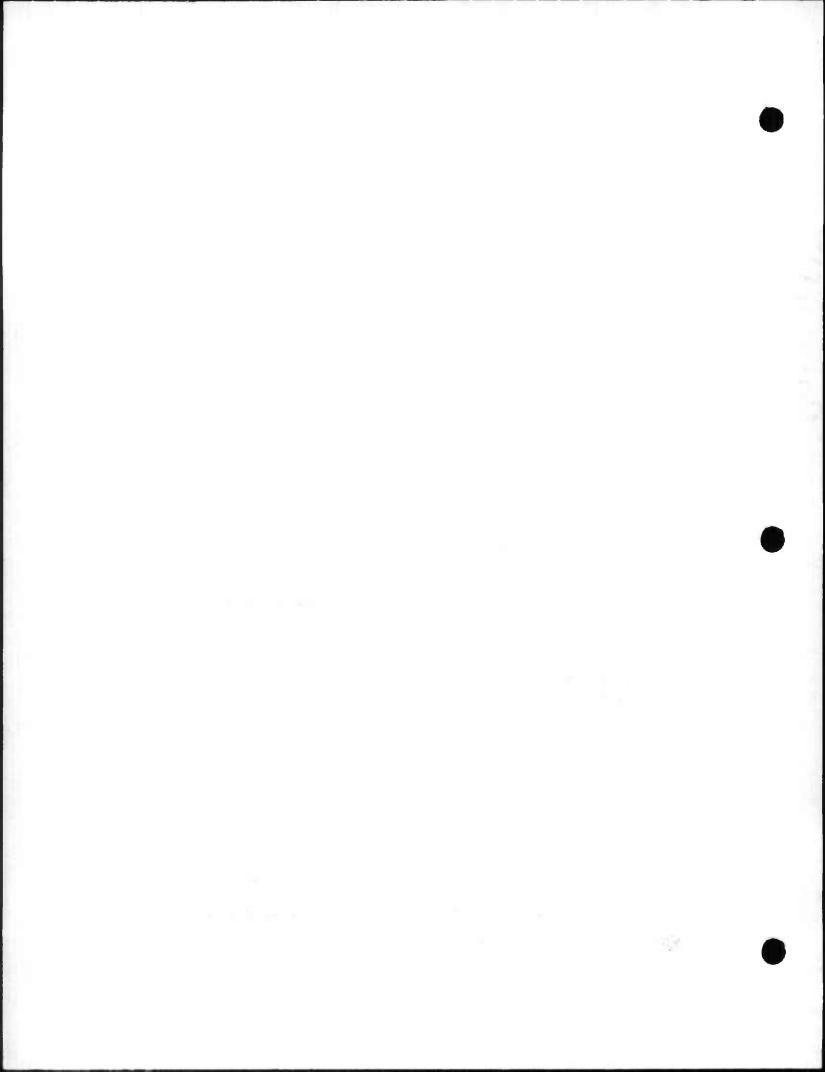
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE BEGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	NEGISTRAN		C	ERITE	CATE	UF	DEAL	П	R	IEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF I	DEATH	v	WEAR	3. TIME OF OEATH
	PHILOMENA	Vľ	VITO				Mar 12 1995				7:20 pm		
	4. SOCIAL SECURITY NUMBER					last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7.			7. DATE OF E	BIRTH		8. BIRTH	PLACE (State or Foreign
- 8	219-26-1261	1 D M 2 NOV. 8, 1914							Mary	land			
	9e. FACILITY NAME (If not institution, give s	treet end number)			9b. CITY,	TOWN C	OR LOCATIO	N OF DE		, 1		INTY OF D	
E	Saint Joseph Me	edical Cente										more	
Ĕ.	RESIDENCE OF DECEDENT				Towson, Maryland Baltim						HIOLE		
DIRECTOR	10e. STATE 10b. COUNTY	1		10c. CITY	r, TOWN OF	R LOCAT	JON.						10d. INSIDE CITY
<u></u>													LIMITS?
4	10e. STREET AND NUMBER					101	ZIP CODE				10a, CIT	IZEN OF W	/HAT COUNTRY?
FUNERAL	6116 Belair Road						2120	6				S.A.	
3	11. MARITAL STATUS	12. WAS DECEOENT	MED	13 W	MS OFC			IC ORIGIN? (S	analfu Van			4	
	1 🔀 Never Married 2 🗌 Merried	FORCES? 1		NO	lf If	yes, sp	ecify Cuban	, Mexicar	1, Puerto Rican	i, etc.)	Or 140—		— American Indian, , White, etc.
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: White												te
COMPLETED	15. DECEDENT'S EDUC	CATION	16a. DE	CEDENT'S	USUAL OC	CUPATIO	ON .		16b. KIN	D OF BUS	INESS/IN	OUSTRY	
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(G life	ive kind of w Do NOT us	rork done du e retired.)	uring mo	st of working	7					
립	8th Grade		Ho	omema	ker				Own	1 Hom	10		
8	17. FATHER'S NAME (First, Middle, Last)						16 MOTH	FR'S NAI	ME (First, Middle				
0	Pasquale	V	ito				_	cett		o, rerendent c	surrieirie)		Russo
BE	19a. INFORMANT'S NAME (Type/Print)		19	h MAILING	ACCRESS	(Street a			loute Number, C	16	0.4.7		1000
임	Michael L. Vito												21.020
ŀ	20a. METHOD OF DISPOSITION												21030
	1 Buriel 2 Cremation 3 Remo	oval from State	20b. PLACE / cemetery_cre H1111	matory or ot	her place	TION (Na	$^{maor}3/1$	L5/9:	5 DATE			City or To	1.6.5
	21. SHUNATURE OF FUNERAL SERVICE LIC	ENGER 10	Lutti	Dp S	ervic	e c	OTPO	rati	on	JOM.	son,	Mar	yland
- 1	. 1	1	/		Joh	in C	Mi	ller	, Inc.				
	Jacklein	m. Mu	rjehe	1/	641	.5 B	elaii	r Ro	ad, Ba	ltim	pre.	Mar	yland 21206
	23. PART I. Enter the diseases, or o	omplications that	caused the	ath. Do n	ot enter t	he mo	de of dyln	ng, such	as cerdiec	or respir	etory ar	reat,	Approximeta
	shock, or heart failure. I	List only one cause	on each line	k									Interval Between
	disease or condition	ACLIT	E MYOC	ADDI	AL INE	AD/	TION						Onset and Death
l	resulting in death)		R AS A CONSE			AUNL	TION					<u> </u>	" uny"
,		CEDOIG			,								6 days
፬	Sequentially list conditions,		R AS A CONSEC	DUENCE OF):								o usyr
₹ I	If any, leading to immediate cause. Enter UNDERLYING	CARD	OOBST	RUCT	VE PL	JLM	ONAR	Y DIS	EASE				poknowo
Ĕ	CAUSE (Disease or Injury that initieted events	~	R AS A CONSEC										00407770
CERTIFICATION	resulting in death) LAST	SCHIIZ	OPHREN	VIA.									uakaowa
EDICAL	PART II. Other significant condition	contributing to de	eath but not r	esulting is	the und	lerlying	cause gl	ven in f	Part I. 24a.	WAS AN A		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
	SEIZURE DISORE	DER							_ 1	YES 2	1 1		COMPLETION OF CAUSE OF DEATH?
W W	DEMENTIA												1 - YES 2 - NO
	DID TOBACCO USE CONTR	RIBUTE TO CAU	SE OF DEA	TH YES	S 🗆 N	0 🗆	UNCE	RTAIN					
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEAT									
<u></u>	1 TES 2 NO	HOSPITAL:	R/Outpatient 3	□ DOA	OTHER:	па Ноти	5 □ Res	Idence d	Other (Spe	no/fh/)			
È	27. MANNER OF DEATH	28a. DATE OF IN	JURY	28b. TIME	OF 2	8c. INJU	JRY AT	T .	28d. OESCRIB		JURY OC	CURED	
	1 Natural 5 Pending	(Month, Day,	Year)	INJL	JRY M	WOI	RK7 ES 2	99					
À A	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF I	NJURY — At ho	me, farm, st	reet, tactor				281. LOCATION	N (Street or	nd Mumba	or Burni Br	nesta Membar
3	4 Homicide determined	building, etc	:. (Specify)						City or Tox	vn, State)	-0 110111001	Or Figure 14	oute Typinipet,
COMPLEI	29a. CERTIFIER		and the little of the										
ğ		CIAN: To the best of m											
3	2 MEDICAL EXAMINER		ninition end/or i	nvestigation	, in my opi	Inlon, de	eth occure	d at the t	ime, date end	place, and	due to th	ne ceuse(e)	end menner as stated.
2	29b. SIGNATURE AND TITLE OF CERTIFIER	20					29c. LICEN	ISE NUMI	BER		29d. DAT	E SIGNED	(Month, Day, Year)
5	Joans	my					D	258	86		•	3.1-	2.95
-	30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM	4 27) (Type,	Print)	-							
	LILIA CEBALLOS			OAD	TOWS	SON	, MAR	YLAN	ND 2120	4			
	31. DATE FILED (Month, Day, Year)	22 REGISTRAR	SIGNATURE										
	MAR 1 4 1995 July	A PURUSUAL PROPERTY	atte.										1



BALLIMORE, MARYLAND 21215-0020	A hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and commentery filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should	n, av removal.	e medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, F.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours when death character be residented by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and commentery in	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cuernation, or removal	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

2

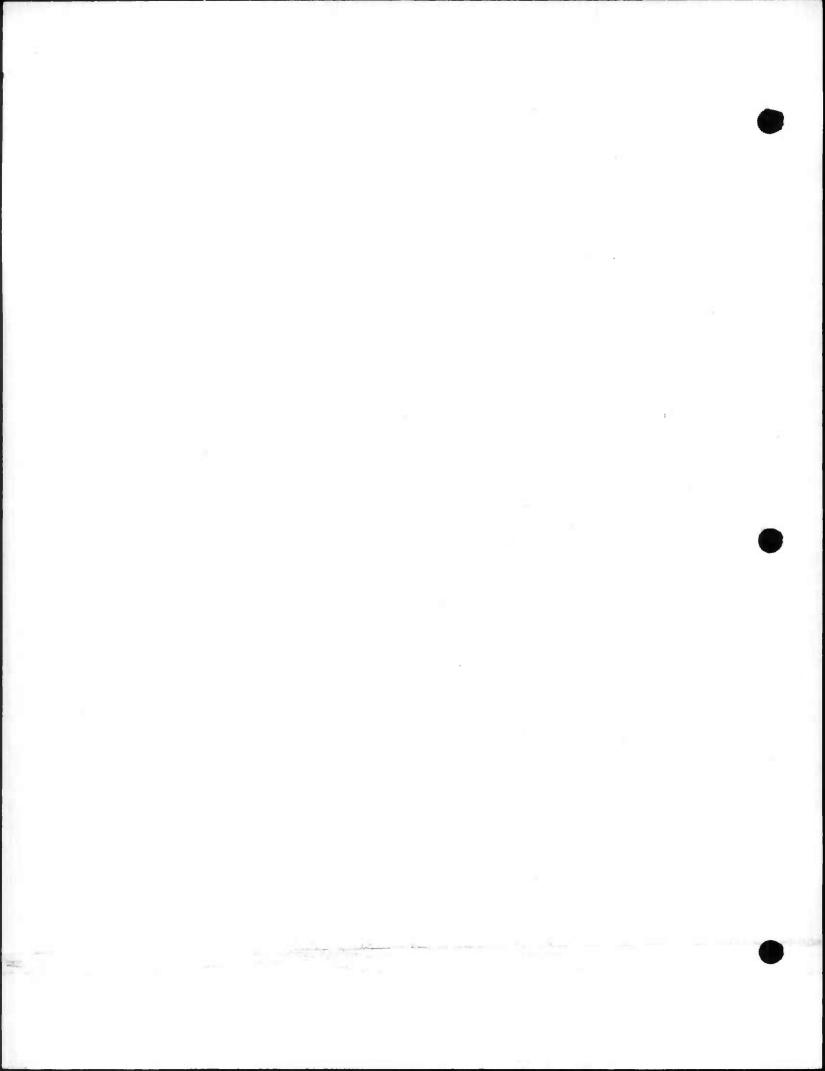
										(95	0769	98
	1 - STATE REGISTRAR	STATE OF !	MARYLAND /	DEPAR ERTIF	TMENT OF	HEALTH A	ND W		IYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY Y									YEAR	3. TIME OF DEAT	πн Λ	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last		IF UNDER 1 YEAR		HRS.	7. DATE OF E	SIRTH May)	-	8. BIRTH	IPLACE (State or F	oreign
	220-62-6067 90. FACILITY NAME (If not Institution, give st	1 M 2 F	42	YRS.	9b. CITY. TOW	N OR LOCATION		APRIL	25,		MAT INTY OF D	RYLAND	
TOR	LAUREL REGIONAL H				90. GIT, 10	LAURE		AID.				GEORGE	
DIRECTOR	10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN OR LO							10d. INSIDE CITY	Υ
	MARYLAND 100, STREET AND NUMBER	HOWARD				COLUME	BIA			017		1 X YES 2 -) NO
FUNERAL	6280-E FORELAND	3ARTH				21045				-	USA	WHAT COUNTRY?	
	11. MARITAL STATUS 1 Never Merried 2 Merried	FORCES? 1	NT EVER IN U.S. ARI	MED	If yes,	ECENDENT OF I	Mexican,	, Puerto Rican	pecify Yes 1, etc.)	or No—	14. RACE Bleck	E — American Indi k, White, etc.	len,
) BY	3 Wildowed 4 Divorced	IF YES, GIVE W	WAR OR DATES		1 🗆 Y	ES 2 NO	Specify:				Speci	"y: WHITE	
ETEC	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Gi	CEDENT'S ive kind of v Do NOT us	USUAL OCCUPA work done during se retired.)	TION most of working		16b. KIN	D OF BUS	INESS/IND	DUSTRY		
COMPLETED	12	College (1-4 or 5	+)		MATOR			C	ONST	RUCT	ION		
BE CO	17. FATHER'S NAME (First, Middle, Last) THOMAS P. WARING					BA	ARBA	RA ST	ANBA	UGH			
10	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) ELWOOD L. WATKINS 645 HILLMEADE ROAD, EDGEWATER, MD 2103									37			
	20e. METHOD OF DISPOSITION 1									wn, State YLAND			
-	21. SIGNATURE OF FUNERAL SERVICE CIG	Edella	abai		760	1 SAND	of faci	PRING	ECK ROAD	FUNE1 , LAI	RAL I UREL,	HOME, IN , MD 207	VC. 707
	23. PART L'Enter the diseases, or e shock, or heart faffure. I	complications that List only one call	caused the de	ath. Do n	ot enter the r	node of dying	, auch	an cerdisc	or respir	atory srr	rest,	Approxim interval B	Setween
	disease or condition resulting in death)		Designe gm									Onset and	d Death
		DUE TO	DUE TO (OR AS A CONSEQUENCE OF):						0		-		
TION	if any, leeding to immediate	bOUE TO	(OR AS A CONSEC	Alcoholic Liver dese AS A CONSEQUENCE OF: Possible peri tonit s					0	<u></u>		12	`
TIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events	DUE TO	Po 50	SUENCE OF	e pen	i ton	h	5				Day	5
CERTI	resulting in deeth) LAST												
	PART II. Other significent conditions	a contributing to	deeth but not n	esuiting i	n _\ the underly	ing cause give	en In P	ert i. 24a.	. WAS AN A		24b.	WERE AUTOPSY FI	
EDIC	Coogulopal	Ty . A	730 te	n.9	Thro	m bocy	to be	emig 10	YES 2	NO		AMAILABLE PRIOR COMPLETION OF (OF DEATH?	
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 NO	☐ UNCER	RTAIN	_				1 TES 2	NO
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	E OF OEAT	H (Check only on								
HYS	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 -		DOA 28b. TIME	4 Nursing He	oma 5 🗆 Resid	-	Other (Spe 28d. DESCRIB		LIURY OCC	CURED		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation		(Month, Day, Year)			WORK?	- 1				-		
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE O building,	OF INJURY — At hore, etc. (Specify)	ne, farm, st	treet, fectory, of	fice		261. LOCATION City or Tox		nd Number	or Rural R	oute Number,	
COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER) end manner ee s	stated.
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENS	SE NUMB		,	29d. DATE		(Month, Day Year)	

		r	1600	ריינ	7	> -	-1			-	
	_				-	-					
30.	NAME	AND	ADORESS	OF PERSON	N WHO	COME	FTED	CALISE	OF DEATH	/ITEM 27	n Okan

29c. LICENSE NUMBER D 2 8 9 9 8

29d.	DATE S	GNED	(Mont	h, Day	Year)
	3	-	4-	15	5

PRITAM	7	SAINI	PAD D	9(0) Cherry	y (N + 211	Lamel	MD 207	08
				1.				



DHMH-16 Ray 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE OF	DEATH	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) HOLLAN					2. DATE OF I	DEATH	YEAR	3. TIME OF OEATH	
			FONG		March			4:30 A M		
	111 20 GEED	5. SEX 6. AGE (III	r yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (S Country) 108 31 25 (Tennesse			· ·	
	9e. FACILITY NAME (If not institution, give stre				R LOCATION OF OE	ATH	9c. 0	OUNTY OF D		
6	1056 Armistead W	ay		Baltim	ore			N/A		
딥	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION				10d. INSIDE CITY	
- DIR	Md.	N/A		ltimore				LIMITS?		
FUNERAL DIRECTOR	1056 Armistead W	ay		101	21 205			citizen of w USA	VHAT COUNTRY?	
5		12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENOENT OF HISPANI ecify Cuben, Mexicen	IC ORIGIN? (S	pecify Yee or No-	- 14. RACE	- American Indian,	
ВУ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	res X	1 TYES			i, etc.)	Amer		
	15. DECEDENT'S EDUCA (Specify only highest grade of		16e. DECEDENT'S U	JSUAL OCCUPATION done during money retired.)	N st of working	16b. KIN	D OF BUSINESS	INOUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (t-4 or 5+)	Housew			7	At Home			
M	17. FATHER'S NAME (First, Middle, Last)		nousew	OLK	F					
ö	Henry Clay Har	npton			16. MOTHER'S NAM Ethel			e)		
BE	19e. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street a	nd Number or Rural A	400		7in Code)		
2	Eugene Wilfond	3	1056	Armistea	nd Way Ba	lto.,N	id. 212	05		
	20e. METHOD OF DISPOSITION 152 Burlet 2 Cremetion 3 Remove		PLACEANDDATEO		nie of	OATE	20c. LOCATION	— City or To	wn, Stata	
	4 Oonetion 5 Other (Specify)	(bak Lawn	Cemeter		3–95	East	wood, M	id.	
	21. SIGNATURE OF FUNERAL SERVICE LICE	Meder		Charl	es S. Ze	iler 8	Son I	nc.		
	Charles D.	, ,		6224	Eastern	Ave. E	Balto.,	Md.		
	23. PART I. Entar tha diseasaa, or co shock, or heart failure. Li	mplications that caused at only one cause on as	the death. Do no	of anter the mo-	da of dying, such	as cardiac	or reaplicatory	srreal,	Approximate interval Between	
	IMMEDIATE CAUSE (Final disease or condition		0,						Onest and Death	
	resulting in death)	CASSINC	CONSEQUENCE OF	0						
7	200									
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR AS A):						
S	cause. Enter UNDERLYING CAUSE (Disease or injury	Bress	t C	K					1	
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
5	d.									
	PART ii. Other algnificant conditions	contributing to death bu	t not resulting in	the underlying	cause given in F	Part I. 24a	WAS AN AUTOP	SY 24b.	WERE AUTOPSY FINDINGS	
EDICAL						_ 1	YES 2 NO		AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?	
ME						_			1 - YES 2 - NO	
	DID TOBACCO USE CONTRI				UNCERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF GEATH	OTHER:						
ίΥS	1 VES 2 NO	I Inpatient 2 ER/Outpa	tient 3 DOA	4 - Nursing Home	5 Neeldence 8					
	Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	RY WO	PRY AT PROPERTY OF THE PROPERT	28d. OEŞCRIB	E HOW INJURY	DCCUREO		
BÁ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, farm, st			28f. LOCATION	N (Street and Nurr	nber or Rural R	oute Number	
TED	4 Homicide detarmined	building, etc. (Specif	γ)			City or Tox	vn, Stete)			
1 2	290. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowle	dge, death occurred	at the time, date	end plece, and due t	o the cause(e)	end menner ee	stated.		
COMPLET		On the basis of examination) end manner ee stated.	
шШ	29b. SIGNATURE AND TITLE OF CERTIFIER	,			29c. LICENSE NUM	BER	29d. 0	ATE SIGNED	(Mgnth, Day, Yeer)	
TO B		MANUTA N	10		1)4329	0	•	3/13	3/45	
F	30. NAME AND AGORESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, I	on Ave	73.1	timer	, 212	24		
ľ	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		1,100	V ~ 1	7016		- 1		
	MAR 1 4 1995 Ju	Un Devolver Ran	611							

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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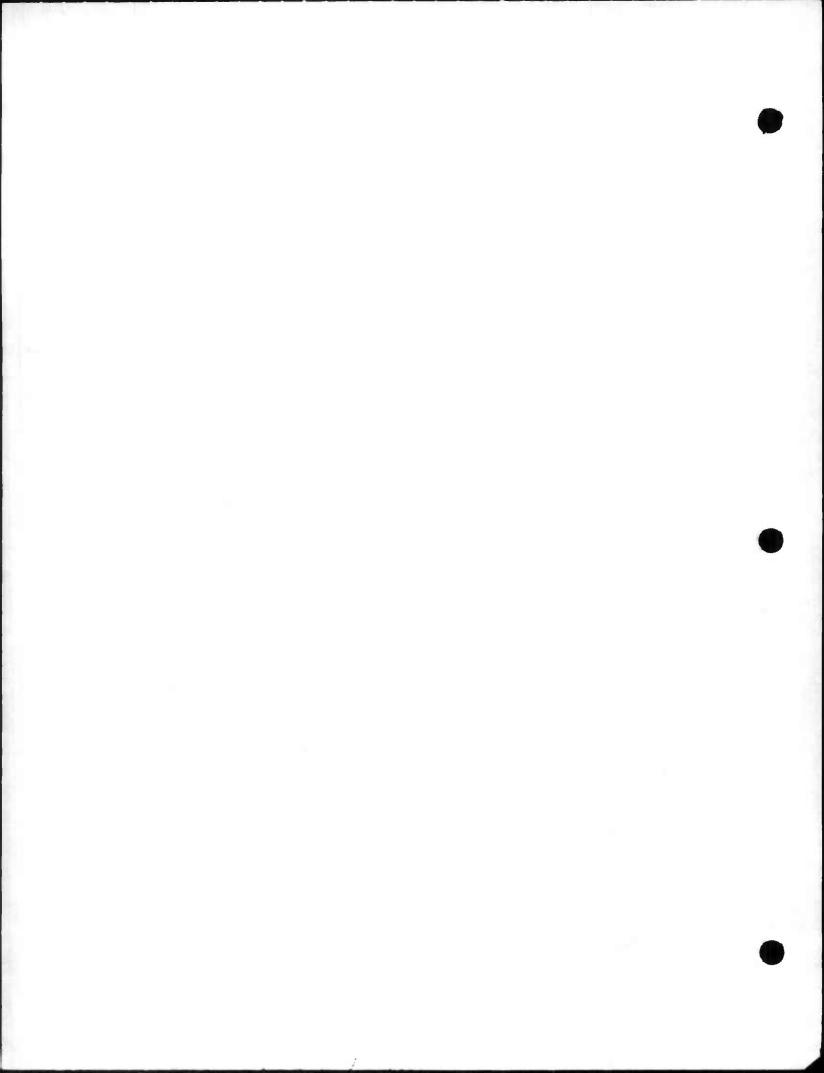
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERT	IFICATE	E OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2.	DATE OF DEATH			3. TIME OF DEATH	
	ELIZABETH PA	RKER W.	HITE					MARCH 8	, 199	YEAR	11.00 4 4	
	4. SOCIAL SECURITY NUMBER 5.	. SEX 8. AG	E (In yrs. last birtho	ay) IF UNDER	1 YEAR	IF UNDER 24 HI	\rightarrow	DATE OF BIRTH	, I) :		11:09 A.M	
	217-22-6899	□M2 VF S	5 YR	S. MONTHS	DAYS	HOURS MI		(Month, Day, Year)	20	Count	(אר	
	9a. FACILITY NAME (If not institution, give street	TOWAY (NOV.21,1909 VIRGINIA OR LOCATION OF DEATH									
Œ	2126 WILKENS AVENUE			Pa. Cit		LTIMOR					RE CITY	
DIRECTOR	RESIDENCE OF DECEDENT										KE OIII	
<u> </u>	10a. STATE 10b. COUNTY		10c.	CITY, TOWN C	R LOCAT	TION					10d. INSIDE CITY	
告	MARYLAND B.	ALTIMORE C	TTV	RΛ	תדידי דידי	MORE					LIMITS?	
	10e. STREET AND NUMBER	TELLIONE O	111	DA		I. ZIP CODE			10- 007	17511 05 1	1 X YES 2 NO	
FUNERAL	2126 WILKENS AVENU	C.			100							
Z I		C. WAS DECEDENT EVER				21223					J.S.A.	
	1 Never Married 2 Married	FORCES? 1 YE	S XXNO	13.	WAS DEC	ecify Cuben, Me	SPANIC C exican, Po	PRIGIN? (Specify Yes	or No-	14. RACI Blaci	RACE — American Indien, Black, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1	YES	2 X NO S	pecify:			Spec	"y: WHITE	
	15. DECEDENT'S EOUCAT	ION	16e. DECEOEN	TIO HOUSE OF	20110471						WILLE	
Ë	(Specify only highest grade con	npleted)	(Give kind	of work done of use retired.)	during mo	ost of working		16b. KIND OF BUS	HNESS/INC	DUSTRY		
7	Elementary/Secondary (0-12) C	College (1-4 or 5+)			D							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		HOI	1EMAKE	K			HOMEN		IG		
	CHARLES B. WADDEY							First, Middle, Maiden				
H								I E. KENT				
2	19e. INFORMANT'S NAME (Type/Print)							Number, City or Town				
. 1	JAMES A. WHITE						UE -	- BALTIMO	RE,	MD	21222	
	20e. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 Removal		0b. PLACE AND DA emetery, crematory		ITION (Na	ame of	1	OATE 20c. LO	CATION —	City or To	wn, State	
	4 Donation 5 Other (Specify)		LOUDON I	PARK C	EMET	ERY	13	3/13 BA	LTIM	ORE		
- 8	21. SIGNATURE OF FUNERAL BERVICE LICENS	3/1	1			ND ADDRESS OF						
- 8	· /1. Illat	Wen	ran					HOME, IN				
	23. PART I. Enter the diseases, of com	plications that caus	ed the death. D	o not enter	the mo	de of dylan	AVE	NUE-BALT	IMUK	E, M	D Z1ZZ9 Approximats	
	anock, or heert failure. List	t only one cause on	sech line.	1-		1 ,	1 -	p -		/	intarval Between	
	IMMEDIATE CAUSE (Finel disease or condition		(- H	-+		211	al	Wal +	7111	0	Onset and Death	
	resulting in death)	DUE TO (OR AS	A CONSEQUENC	7								
		DOE TO (OH AS	CI	1/1/	1	-16,1	10	atri				
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): C OF BY LOTTE DUE TO (OR AS A CONSEQUENCE OF): C OUE TO (OR AS A CONSEQUENCE OF): C											
A	If any, leeding to immediate cause. Enter UNDERLYING	A Property of the Parket		117	N							
윤	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
E	resulting in deeth) LAST			0.000							1	
빙	d											
甘	PART II. Other aignificant conditions of	ontributing to deeth	but not reaulting	ng in the un	derlying	g cause given	in Part	I. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS	
EDICAL								1 TYES 2	4		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									46		OF DEATH?	
Σ	DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEATH	YES D N	IO F	LINCEPT	AIN F	¬ [1 YES 2 NO	
4	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF D			OTTOLIKI	WILL F					
22		OSPITAL:		OTHER	1:	-/						
PHYSICIAN:	27. MANNER OF DEATH	Inpetient 2 ER/Ou 28e. DATE OF INJURY		TIME OF	28c, INJ	e 5 Residen	_					
	1 Natural 5 Pending	(Month, Day, Year)	200.	INJURY	WO	RK?	260	I. DEŞCRIBE HOW IN	IJURY OCC	CURED		
à I	2 Accident Investigation		** ***	- "		res 2 No						
	3 Suicide 6 Could not ba 4 Homicide determined	28e. PLACE OF INJUI building, etc. (Sp	RY — At home, fan ecify)	n, street, fecto	ory, office		261	. LOCATION (Street & City or Town, State)	nd Number	or Rural F	loute Number,	
6 N												
ᆲ	29e. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the beat of my kno	wiedge, death occ	urred at the ti	me, date	end place, end	due to th	e ceuse(e) end man	ner ee atat	ed.		
COMPLETE	one) 2 MEDICAL EXAMINER: 0	on the basis of examinat	ion end/or inveatig	ation, in my o	pinion, d	eath occured at	the time.	date end place, end	due to th	e ceuse(e) end menner ee stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	10	11			29c. LICENSE	NUMBER	/	29d. DATE	E SIGNED	(Month, Day, Year)	
BE	V	Mary	1			D26	20	14	> 3	3/2	195	
유	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE(OF D	EATH (ITEM 27) (7	rpe, Print)		2 4 4			ب	100		
	DR. LUIS ZUNICA		01 MAIDE		ICE	LANE	-	BALTIMO	RE,	MD	21227	
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIG	NATURE									
11	MAR 1 4 1995	Jalia Dava	an Parlat	į.								



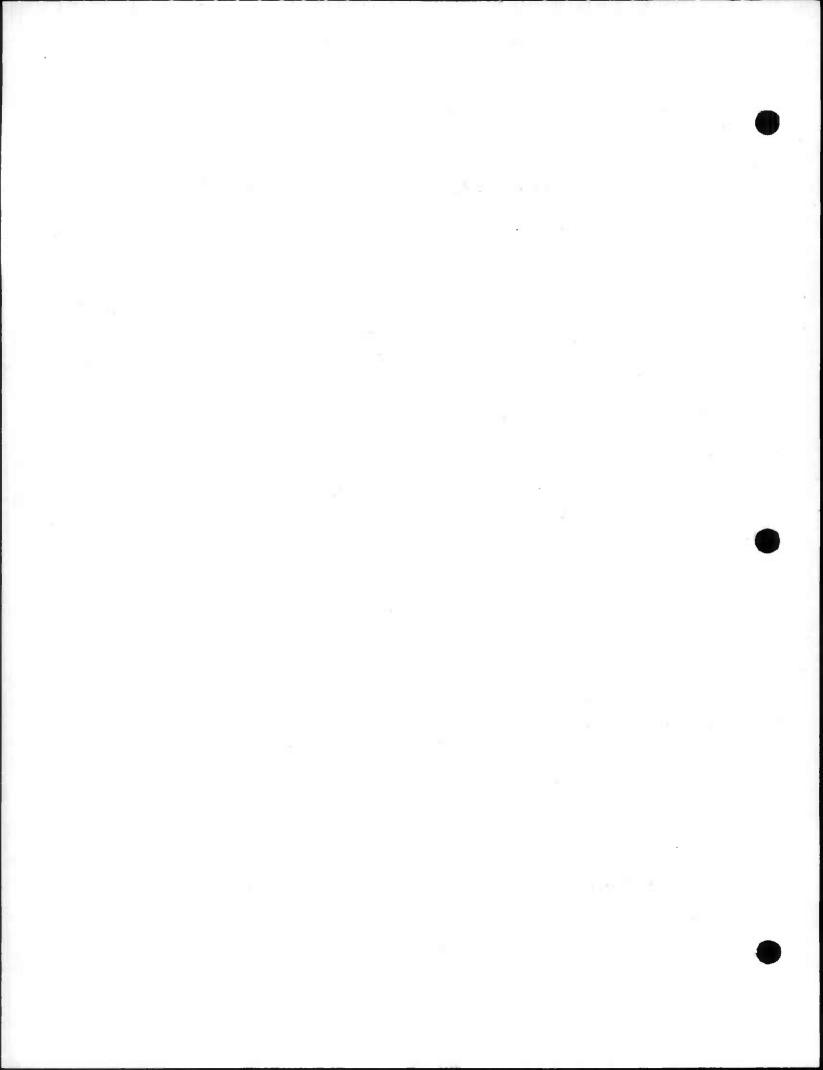


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BALLIMORE, MARYLAND 21215-0020	urs after death. Page 6 may be retained by the hospital or attending physician.	In by the funeral director, page 5 should be detached for use as the burial-transit perm r removal.	edical examiner must be notified at once.	
DIVISION OF VI AL RECORDS, F.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

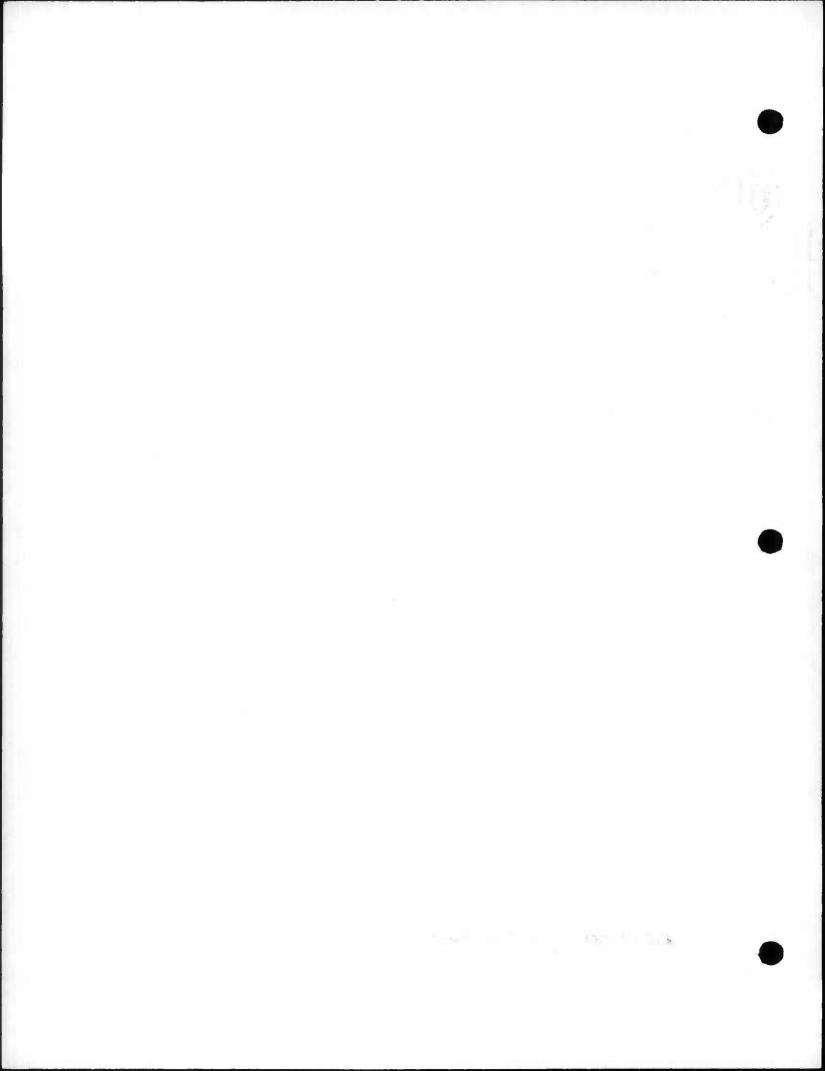
	1 - FOR STATE OF MARYL REGISTRAR		MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH					
	REGINA L.	WI	LLIAMS	MARCH 11, 1	1995 YEAR 10:40 PM					
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE		FUNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign					
	UNK. 1 M 2 [T.EC] 41 YRS. MONTHS DAYS HOURS MIN. (MONTH, Day, Year) Country Ba									
	9a. FACILITY NAME (If not institution, give street and number)	9	L CITY, TOWN OR LOCATION OF D		Baltimore Baccounty of DEATH					
OR	THE JOHNS HOPKINS HOSPITAL		BALTIMORE CI	TY	Na					
123	RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY	I too CITY T	OWN OR LOCATION							
DIRECTOR	MD Baltimore		Dundalk		10d. INSIDE CITY LIMITS?					
	10e. STREET AND NUMBER		101, ZIP CODE	I 1	1 YES 2 NO					
ER/	2067 Kelmore Rd.		21222		USA					
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER I	N Ų,S, ARMED	13. WAS DECENDENT OF NISPA	NIC ORIGIN? (Specify Yea or	No 14. BACE — American Indian					
BY F	1 Never Married Married FORCES? 1 YES 3 Widowed 4 Divorced FORCES? 1 YES		Il yes, specify Cuban, Maxica 1 YES 2 NO Specifi	n, Puerlo Rican, etc.)	Black, White, etc. Specify:					
					Black					
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during most of working	16b. KIND OF BUSINE	ESS/INDUSTRY					
12	Elementary/Secondary (0-12) College (1-4 or 5+)	Domes	. *	Ч	ome Maker					
MO	17. FATNER'S NAME (First, Middle, Last)	Domes		ME (First, Middle, Maiden Sun						
	Eugene Walker		Unk.	IME (First, Middle, Maiden Sun	name)					
BE (19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Rural	Route Number, City or Town, S	State. Zin Code)					
욘	Ilisha Davis		Dundalk Ave							
	20a. METNOD OF DISPOSITION 20Berround from State	PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c. LOCAT	TION — City or Town, Stata					
	4 Dignation 6 Other (Specify)	netery, crematory or other loshells	Memorial	3/16 B	Baltimore, MD					
	21. SECHATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FA	outy	ns Funeral Home					
	James U. Mol	Color			to., MD 21217					
	23. PART L Errer tha diseasea, or complications that ceuse sheek, or heart failure. List only one cause on e	d the deeth. Do not	enter the mode of dying, suc	h as cardisc or respirate	ory srrest, Approximate					
	IMMEDIATE CAUSE (Final	ach iina.			Interval Between Onset and Death					
	disease or condition s. INTRACET	REBRAL	HEMORRHAGE		124 Hours					
					7					
NO	Sequentially list conditions, b. THROMB	CONSEQUENCE OF):	NIA		7 DAYS					
ATI	ii any, reading to miniediste	NFECTIO			1/2000					
	CAUSE (Disease or Injury	CONSEQUENCE OF):	17		O IVLONIAS					
CERTIFICATION	resulting in death) LAST									
	PART II. Other significant conditions contributing to deeth b	urt not requisited to t	ha madalilatan ana atau ta	n ()						
CAL	to death a symmetry continuing to death a	or nor resolding in a	ne underlying cause given in	PERFORME	D? AMILABLE PRIOR TO					
<u> </u>				1 YES 201	NO COMPLETION OF CAUSE OF DEATH?					
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE O	E DEATH VES	□ NO □ UNCERTAII		1 - YES 2 NO					
IAN	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH		AI						
Sic	EXAMINER? 1 YES 2 NO 1 Noting the state of		THER: Nursing Nome 5 Residence	6 Other (Specify)						
훉	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 26c, INJURY AT	28d. DESCRIBE HOW INJU	RY OCCURED					
BY	Netural 5 Pending (World, Day, Year) Accident Investigation	INJUN.	M 1 YES 2 NO							
	3 Suicide 6 Could not be 28e. PLACE OF INJURY	— At home, farm, stree	et, lactory, offica	261. LOCATION (Street and a City or Yown, State)	Number or Rural Route Number,					
COMPLETED	4 Homicide detarmined									
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my know									
S S	one) 2 MEDICAL EXAMINER: On the basis of exemination	n and/or investigation, i	n my opinion, death occured at the	time, data end place, and du	us to the cause(s) and manner as stated.					
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI	MBER 29	Pd. DATE SIGNED (Month, Day, Year)					
10 B	paul Vonchese M. I),	M61	80 1	MARCH 11, 1995					
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type, Pri	A		/					
		110 IN	JOHN'S HOP	KINS HOS	PITAL					
	MAR 1 4 1995 Julia Marchan Rank									
	THE T T ISSO SHOW WINDOWS TOWN	ц								





	_	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND (/ DEPAR	TMENT OF CATE OI	HEALTH AND F DEATH	MENTA	L HYGIEN					
D		1. DECEDENT'S NAME (First, Middle, Last	G.			AITSM	AN	2. DATE MOND MAR	OF DEATH	5 19	95 3.	12:40 P		
		4. SOCIAL SECURITY NUMBER UNKNOWN	1 XM 2 - F	E (In yrs.	lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	(Mon	OF BIRTH th, Day, Year) R. 15	- 1	Country)	ACE (State or Foreign RYLAND		
T	TOR	9a. FACILITY NAME (If not institution, give 8060 MILTON RESIDENCE OF DECEDENT					NN OR LOCATION OF DEATH DLAWN BALTIMORE							
٣	DIRECTOR	10a. STATE 10b. COUN MARYLAND BAL!			TOWN OR LOC	ATION 10d. INSIDE C LIMITS? 1 YES 2								
nsit permi	ERAL	100. STREET AND NUMBER 8060 MILTON AVE	NUE			1	IOF. ZIP CODE					AT COUNTRY?		
5-0020 nding physician. is the burial-transit.	BY FUN	11. MARITAL STATUS 1 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	\$ 24		It yes, s	ECENDENT OF HISPA specify Cuban, Maxic ES 2 NO Speci	en, Puerto			4. RACE -	American Indian, thite, etc. WHITE		
2121 al or atte for use a	PLETED	15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)		(Give kind of w life. Do NOT use	USUAL OCCUPATION done during in petired.)	TION nost of working	166		BUSINESS/INOUSTRY				
ALA by the be det	E COMPL	17. FATHER'S NAME (First, Middle, Last) HARRY WA]	ITSMAN		DONGER	THICER	18. MOTHER'S N	AME (First,		Surname)	PMAN			
e retained e 5 should notified	TO BI	19a. INFORMANT'S NAME (Type/Print) MRS . HANNA SACH	KS				and Number or Rura	Route Num	ber, City or Tow	m, State, Zip C	SHERMAN			
MORE, age 6 may be director, page		20a. METHOD OF DISPOSITION 1 By Burlal 2 Cremation 3 Rail 4 Donation 5 Other (Specify)	moval from State	ob. PLAC emetery .	EANDDATEO	FDISPOSITION (I	Vame of	3/9/	E 20c. LO	CATION — CH	ty or Town,			
death. P funeral examin		21, SIGNATURE OF FUNERAL SERVICE L			SOL	LEVINSON	ACILITY V & B	ROS.,I	NC.	ORE,MD.				
in 24 hours sly filled in 1 lation, or re-		23. PART I. Enter the diseases, or shock, or heert failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that cause complications that cause on List only one cause on a. S'LLOWS DUE TO (OR AS	IM.	HALA	ot enter the m	oode of dying, au	ch aa cere	disc or respi	iratory arres	it,	Approximate interval Between Onset and Death		
P.O. BOX 58 th certificate be executed by the physician and Hygiene prior to bur or other traumatic	ERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. DUE TO (OR AS											
records v requires that the been signed by the t, of Health and M shows any Inju	N: MEDICAL C	PART II. Other significant condition						_	24e. WAS AN PERFOR	RMED?	CO OF	ERE AUTOPSY FINDINGS ANLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO		
	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou			OTHER:		8 🗆 Othe	r (Specify)					
ATTENDING PHYSICIAN: The ECTOR: After this certificate h s after death with the State C 28 Is marked, or liem	BY	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide a Continuous	28a. OATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY	-	28b. TIME INJU	M 1 🗆	JURY AT ORK? YES 2 NO	Surs		1 140	USEF			
S S S S S S S S S S S S S S S S S S S	LETED	4 Homicide Could not be determined	HO	ME				866	ATION (Street a or Town, State)	DUAVO	& BAU	suppose typ		
HOSPITAL FUNERAL WITHIN 72 MANT: II	COMPLETE	2 MEDICAL EXAMIN	ER: On the basis of examination				death occured at the	time, data		d due to the o	cause(a) an			
TO THE De filed IMPOR	TO BE	29b. NOME AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WI	Thele	EATU AV	EM 27) (Type, F	Delast	O.C.M					6,1995		
		HAMPON LOD A 31. DATE FILED (MONTH, Day, Year)		11			EET,BAL	TIMO	RE,MA	RYLAI	ND 2	1201		

31. DATE FILED (MONTH, Day, Year)
MAR 1 4 1995



3. TIME OF DEATH

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law

2. DATE OF DEATH RAY MOND WILEY R MARCH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 24 HRS. 212-29-1 M 2 - F YRS. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 90 COUNTY OF DEATH DIRECTOR RESIDENCE SCLOWN 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION IOd. INSIDE CITY YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL ZIP CODE 10g. CITIZEN OF burlal-transit 21 physician 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, Whita, etc. 1 Never Married 2 Married YES 2 NO Specify: BY 3 Widowed 4 Divorced retained by the hospital or attending funeral director, page 5 should be detached for use as the COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY College (1-4 or 5+) notified at BE 2 must be 20b. PLACE AND DATE OF DISPOSITION (No the medical examiner OF FUNERAL SERVICE LICENSEE certificate has been signed by the attending physician and completely filled in by the htte State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Intarvai Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) CONGESTIVE HOART FAILUNG event, DUE TO (OR AS A CONSEQUENCE OF): OBSTRUCTIVE PULMONARY traumatic HNONIC MEDICAL CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate DISEASE cause. Enter UNDERLYING other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST ö Injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? shows a 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) SPITAL: OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 8 Char (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY this c marked, 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accide 5 Pending 1 YES 2 NO DIRECTOR: After to hours after death v BY Investigation Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 8 Could not be 28 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and menner se stated. FUNERAL I = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 2 MEDICAL EXAMINER: On the b on and/or investigation, in my opinion, death occured at the fime, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 030272 MANCH 11 onuces 1991 9 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BON SECOURS HOSPITAL 31. DATE FILED (Mo 32. REGISTRAR'S SCHATURE WAR 1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

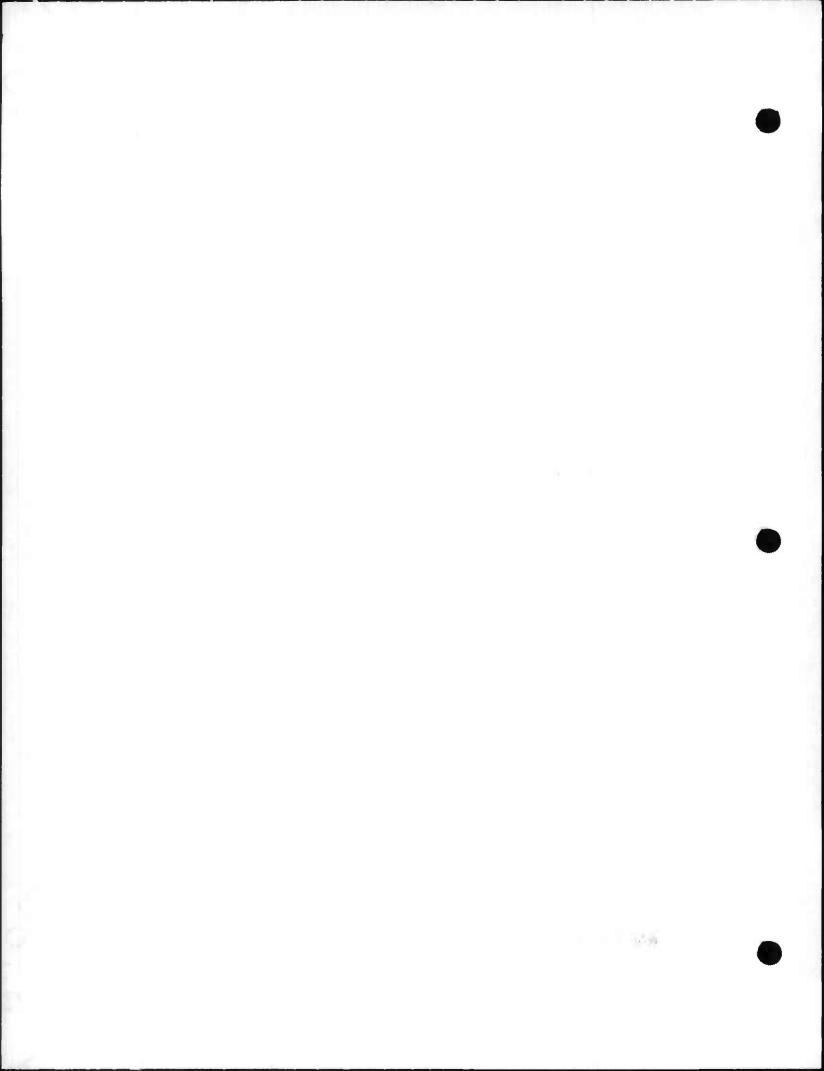
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

							111 107		DEA			HEG. NO.			
		1. OECEDENT'S NAME (First,									2, DATE OF	DEATH			. TIME OF DEATH
		Dorothy	/ Eli:	zabeth	Lasa	ater	Warr	ing	ton		Marc			995	8:30 PM
	1 1	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (//	In yrs. last birt	hday) IF II	NDER 1 YEAR	IE LINDE	R 24 HRS.	7. DATE OF		/• 	111	ACE (State or Foreign
		215 02 1/	C F	1 🗆 M 2 📉 F			RS. MONT			MIN.	(Month, D.	ley, Year)		Country)	
밀		215-03-14			7	9	ns.				Feb.	1,1	916	Penr	sylvania
3 should		Sa. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. (CITY, TOW	N OR LOCAT	ION OF DE	EATH		9c. COUN	ITY OF DEA	TH
60	18	620 Charles Street Avenue Towson										Baltimore			
-,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION									1016				
Ses	W	10a. STATE	10	c. CITY, TOV	VN OR LO	CATION					1	Od, INSIDE CITY			
S.	1 a	Maryland	Ra1	timore			To	wso	22					Ι.	LIMITS?
Ē		10e. STREET AND NUMBER	Dai	CIMOLE			10		10f, ZIP COD	· -			40 01711		2 %
physician. burial-transit permit. Pages 1, 2,	FUNERAL	600 01	_	_					101, 217 600	E			10g. CI112	ZEN OF WH	AT COUNTRY?
an.	ᆝᄬᆝ	620 Cha	rles							1204				USA	10.00
physician burial-tra	5	11. MARITAL STATUS	200.000	12. WAS DECEDEN FORCES? 1		U.S. ARMED		13. WAS 0	ECENDENT (OF HISPAN	NIC ORIGIN? (S	Specify Yea	or No—	14. RACE -	- American Indian, White, etc.
P P	ВУ	1 Never Married 2 📉		IF YES, GIVE V					ES 2 NO			HT, 04C.)		Specify:	White
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r attending use as the	0		EDENT'S EDUC			16a. DECED	ENT'S USUA	L OCCUPA	TION		16b. KJI	ND OF BUS	INESS/IND	USTRY	
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hospital or ached for u	립	Limital y occordacy (o	12)	7	"	D		1 0	1	- 1		. 1 0			
the hospital of detached for once.	COMPLET	17. FATHER'S NAME (First, MI	Iddle Leat			Pers	sonne	21 (leri		0-		ompa	ny	
4-4	8										ME (First, Midd				
	B	Everett		n Lasat	er				E	dith	Unkr	nown	Be	nnet	t
5 should	0	19a. INFORMANT'S NAME (7)	vpe/Print)			19b. M/	ILING AOOF	RESS (Street	t and Number	r or Rural I	Route Number,	City or Town	, State, Zip	Code)	
	F	Mr. W. Sc	ott W	arrinot	on	620	Cha	rla	c Sti	reet	· A 1701	2110	TOTAL	on N	D 21204
ay be		20a. METHOD OF DISPOSITI		di i i i i		PLACEAND				eet	DATE			Off Town	
leath. Page 6 may be funeral director, page xaminer must be		1 N Burial 2 Crematio		oval from State	ceme	etery cremeto	ry or other old	ecel			1				
direct direct		4 Donation 5 Other			<u> Di</u>	ulane	y Va	ille	<u>y Mer</u>	n.Gr	183/1.	Tir	<u>noni</u>	um,	Maryland
death. Page funeral dire i. examiner r		21. SIGNATURE OF FUNERAL	SERVICIOLIS	ENSER			- 1		AND ADDRE						20.00
		Marti	n	1 awan	-0 . —			Mit	chel.	L-Wi	edefe	eld 1	Home		
		22 DADT I Estentha di	п <i>D</i> .	Lawson	0.00			650	<u> </u>	rk R	Road .I	<u>Balt</u>	o.M	D 21	212
5 5 6		23. PART I. Enter the di ahock, or he	eart failure. I	amplications the	it caused ise on es	the death. ich line.	Do not er	iter the n	node of dy	ing, auci	h aa cerdiec	or respin	etory srre	eat,	Approximate Interval Between
		IMMEDIATE CAUSE (FIn	el	0											Onset and Desth
· >= =		disease or condition resulting in death)	→	(a	100	W. /	int.	366	.8-1	97.	ina	P			1/20-
completely fille ial, cremation,		resolung in death)		DUE TO	(OR AS A	CONSEQUEN	ICE OF):		voa	o pu	1 Mas				p
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executed and conto to bunial, matic er	RTIFICATION	Sequentially list conditi		DUE TO	(OR AS A	CONSEQUEN	CE OED								
ysician prior t	A	If sny, leading to immed cause. Enter UNDERLYI					J. J.								i l
7 7 -	일	CAUSE (Disease or Inju			100 10 1										
nding phys Hygiene p	Ē	that initiated events resulting in deeth) LAS'	,	OUE 10	(OH AS A	CONSEQUEN	CE OF):								
th c	E	reading in deetil) LAG		l											
that the dea ed by the att th and Menta any Injury,	CEI	DART II. Osh - a siiii	-A Alal						- wall is						
t the	4	PART II. Other significe	nt conditions	contributing to	death bu	it not resul	ting in the	underly	ing ceuse	given in	Part I. 24	PERFORM			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
thai th a	EDICA											YES 2		0	OMPLETION OF CAUSE
sign Sign Heal												,			F DEATH?
peen of she	Σ.	DID TOBACCO US	SE CONTE	IRLITE TO CA	LISE OF	E DEATH	VEC F	I NO	11810	ERTAIN				1 ,	☐ YES 2 ☐ NO
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attent be filed within 72 hours after death with the State Dept. of Health and Mental HIMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or	PHYSICIAN:	25. WAS CASE REFERRED TO		DOIL TO CA		26. PLACE OF				LKIA(I	۱ L				
The tate	ᅙ	EXAMINER?	- MEDIONE	HOSPITAL:			OTH	IER:	9/						
SIAN intific	ΥS	1 YES 2 NO		1 Inpetient 2	ER/Outpa	itlent 3 🗆 D	OA 4 🗆	Nursing He	ome 5 K R	sidence	6 🗆 Other (Sp	pecify)			
IYSIC is ce is ce ith t	표	27. MANNER OF DEATH		28s. OATE OF (Month, D		28	. TIME OF	28c. I	NJURY AT		28d. OEŞCRI	BE HOW IN	JURY OCC	UREO	
to the state of th	BY		Pending nvestigation				N		YES 2	NO					
Aft. dea	0	3 Cutatda	Could not be	28a. PLACE O	F INJURY -	- At home, t	arm, street,	factory, of	fice		281. LOCATIO	ON (Street ar	nd Number o	or Rural Rou	te Number,
TEN TOR after	ш		fatarmined	bullding,	atc. (Specif	TV)				- 1		own, State)			
IREC IUIS	<u> </u>	29s. CERTIFIER											_		
2 L D 7 L D	鱼	(Check only		CIAN: To the best of											
SPIT.	COMPL	one) 2 MEDI	CAL EXAMINER	: On the basis of a	camination	and/or Inves	tigation, in a	ny opinion	desth occur	red at the	Ilme, data and	place, and	dua lo the	cause(s) s	nd manner as stated.
M FE		296. SIGNATURE AND TITLE	OF CERTIFUER	1					200 1101	ENSE NUM	IDCD.	Т.	And DATE	DIONED (I	
HE HE DE	H H	////	- (/	11.1		~			70	III	2/		Z9G. DATE	SIGNED (M	lonth, Day, Year)
668₹	2	(Nuev	VY	274	M	()			DU	71.	ムも		3	112/	75
		20. WASE AND ADDRESS OF												1	
		Alberto	J. Dia	az, M.D	., 7	/401	Osle	r D	rive,	То	wson,	MD	212	04	
7		31. OATE FILEO (Month, Day,)		2. REGISTRA								_			
0		MAR 1 4	1995	Alli Asi	you k	0 11									1
			744	A 25 SA SER	WAN. N	Woll									

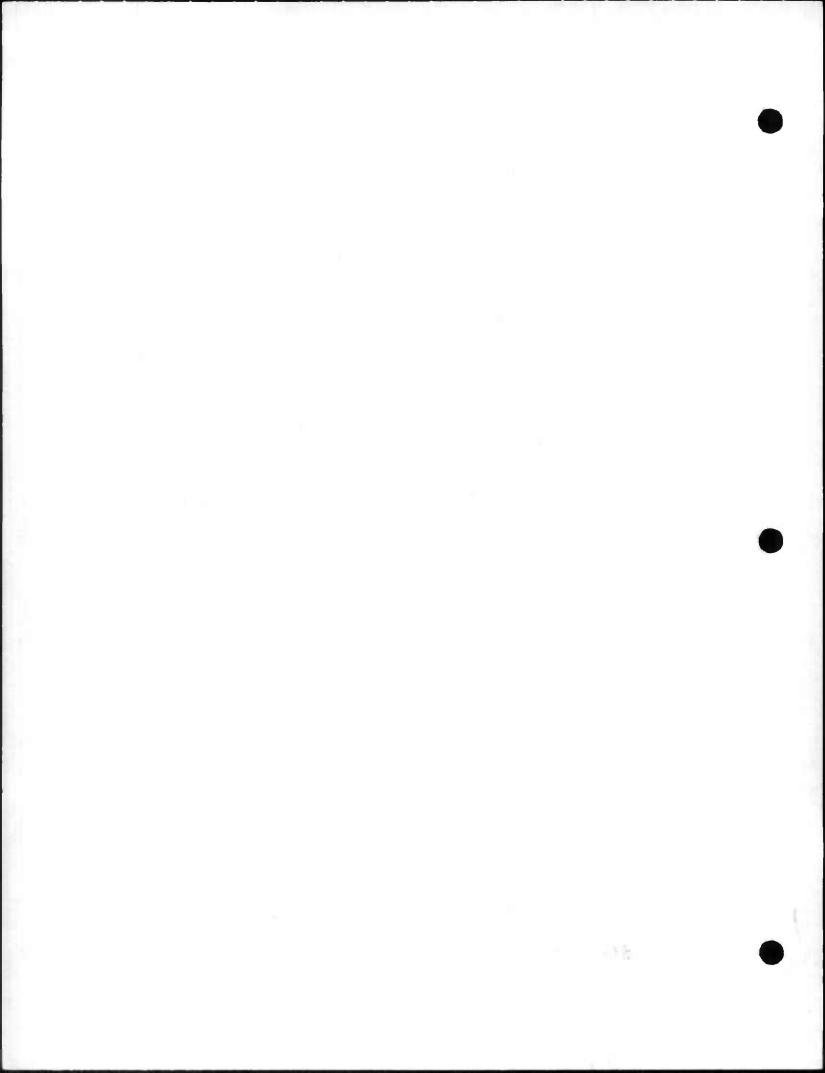


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zer hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunk-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Dopt. Of Health and Mental Hygiene prior to bunkal, cremation, or removal.
IMPORIANT IT HEM 26 IS MARKEY, OF HEM 23 SHOWS ANY INJURY, OF OTHER TRAUMANC EVENT, THE MEDICAL EXAMINER MUST DE NOTINED AT ONCE,

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND /		ENT OF HI		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	Isolina	Gonza	lez-Wr	neeler		March 9	1995	11:15P M			
		BEX 8. AGE (In yrs. last	MON	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Cou	THPLACE (State or Foreign ntry)			
	261–74–4567 1 Department of the street of th	□ M 2 XX F 75	YRS.	CONT. TOWARD OF		May 26, 191		ıba			
Œ			96.	_	R LOCATION OF DE	EATH	DEATH				
5	Greater Baltimore Medi	ical center		Towsor			Baltimore				
DIRECTOR	10e. STATE 10b. COUNTY	l ± ÷		WN OR LOCATI	ON		10d. INSIDE CITY LIMITS?				
	Maryland Bal	ltimore		Towson 101.	ZIP CODE		1 YES 2)(X NO				
FUNERAL	1103 Metfield Road				21286		. A.				
P.	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U.S. ARI		13. WAS OECE	NDENT OF HISPAN	IIC ORIGIN? (Specify Years, Puerto Rican, atc.)	or No- 14, RA	CE — American Indian,			
BY	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 TYES 2)(N IF YES, GIVE WAR OR DATES		XX YES	2 NO Specify	r.	10.00	nolfy:			
	15. DECEOENT'S EDUCATIO			AL OCCUPATION			I SINESS/INDUSTRY	White			
COMPLETED	(Specify only highest grade comp		ve kind of work of Do NOT use reti	done during mos ired.)	t of working						
MP	12		Homema	ker			wn Hame				
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	Surname)				
BE	Enrique Hernandez 190. INFORMANT'S NAME (Type/Print)	196	MAILING ADD	RESS (Street en		ana Guedes Toute Number, City or Tow	n. State. Zip Code)				
2	Sonia Garcia					Maryland 21					
	20e. METHOD OF DISPOSITION 1	20b. PLACE A	ND DATE OF O	SPOSITION (Nan		OATE 20c. LO	CATION — City or	Town, State			
	4 Donation 5 Other (Specify) Greenmount Cemetery 3-11 Baltimore, Marylar										
	Mitchell-Wiedefeld Home										
		len-		6500 Yo	ork Road B	altimore. Mar	ryland 212				
		only one ceuse on each line.	eth. Do not e	enter the mod	le of dying, such	n as cerdiec or respi	ratory srrest,	Approximete Interval Between Onset and Death			
	IMMEDIATE CAUSE (Final disease or condition resulting in death) s. CEREBRAL THROM BOS S DUE TO (OR AS A CONSEQUENCE OF):										
	resulting in deathy	DUE TO (OR AS A CONSEO	UENCE OF):	1000	1						
NO	Sequentially list conditions, b.	SEVENE 147	PERTE	NORM	1						
TA	if any, leading to immediate cause. Enter UNDERLYING	our to four as a couse	DENCE OF J.								
Ĕ	CAUSE (Disease or Injury that Initiated events Due to (OR AS A CONSEQUENCE OF):										
CERTIFICATION	resulting in death) LAST										
AL (PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s WAS AN AUTOPSY 24b WERE AUTOPSY SIMILARY										
DIC	INSULIN DEP	ENDENT	DI MAETES			1 YE\$ 2		COMPLETION OF CAUSE OF DEATH?			
M								1 TYES 2 NO			
AN	DID TOBACCO USE CONTRIBUTION WAS CASE REFERRED TO MEDICAL		H YES L		UNCERTAIN	4 🗆]					
SIC	EXAMINER? /	SPITAL: Inpetient 2 - ER/Outpetient 3	ОТ	HER:	5 Residence	6 Other (Specify)					
PHYSICIAN: MEDIC	27. MANNER OF OEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		RY AT	28d. DESCRIBE HOW II	NJURY OCCURED				
BY	1 Netural 5 Pending 2 Accident Investigation			M 1 YE							
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At hon building, etc. (Specify)	ne, farm, street	, factory, office		28f. LOCATION (Street e City or Town, Stete)	and Number or Rura	Route Number,			
COMPLETED	290. CERTIFIER	To the head of my feet and a second					K-12-12-12-12				
M M		To the best of my knowledge, dea the basis of examination end/or in						(e) end menner as stated.			
E C	29b. S/GNATURE AND TITLE OF CERTIFIER	1,.			29c. LICENSE NUM			D (Month, Day, Year)			
@	Marcio M/	*******	M()		00760	97	▶ March				
2	30. NAME AND ADDRESS OF PERSON WHO COL				-			,			
	Marcio Menendez 31. OATE FILED (Month, Day, Year)	7501 Osler Drive	Suite40	08 Towosi	n, Marylan	d 21204					
	11 ONTE TILED (MOTHE, Day, 1987)	32. HEGISTRAR'S SIGNATURE	2.1.11								
		()	and Ly					OHMH 10 Pay 1700			



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

CONTRACT NO CONTRACT OF CONTRA	TO BE COMPLETED BY DHYSICIAN: MEDICAL CEDTIFICATION
if examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should wal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
ler death. Page 6 may be retained by the hospital or attending physician.	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the norm after death. Page 6 may be retained by the hospital or attending physician.
BALTIMORE, MARYLAND 21215-0020	DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR		STATE OF M	IARYLA				EALTH AND DEATH	MENTA	AL HYGIEN			
1. DECEDENT'S NAME (First,								2. DATE	E OF DEATH			3. TIME OF DEATH
KENNE	TH	E-		WAL	KE	R		MONT	03	09	YEAR	1625 M
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (Ir	n yrs. last birtho	day) IF U	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	00	8. BIRTH	PLACE (State or Foreign
213-54-27	780	1 X M 2 🗆 F	44	4 YF	IS. MONT	THE DAYS	HOURS MIN.		th, Day, Year)	1950	Countr	γ)
9a. FACILITY NAME (If not ins	stitution, give a	street and number)			9b.	CITY, TOWN C	OR LOCATION OF DI		st 17.		NTY OF D	ryland EATH
University	/ Hosp	ital			E	Baltim	ore			N,	/ A	
10a. STATE	10b. COUNT	Y		10c.	CITY, TO	WN OR LOCAT	ION					10d, INSIDE CITY
Md.		N/A			Ba:	ltimor	е					LIMITS?
10e. STREET AND NUMBER						101	ZIP CODE			10g. CITI	ZEN OF V	VHAT COUNTRY?
615 Home	estead	St.					21218				U:	SA
11. MARITAL STATUS		12. WAS DECEDENT					ENDENT OF HISPAI			or No-	14 BACE	- American Indian
1 Never Married 2		FORCES? 1 IF YES, GIVE W			- 1	If yes, spe	2 NO Specific	nn, Puerto ly:	Rican, etc.)		Speci	fy:
3 Widowed 4 Divor	rced	1		V.)			X			I		white
15. DECI (Specify only	EDENT'S EDU highest grade	CATION completed)		(Give kine	d of work d	AL OCCUPATIO	N st of working	160	b. KIND OF BU	SINESS/INC		
Elementary/Secondary (0-		College (1-4 or 5 +		Iffe. Do N	OT use retir	red.)	a or norming					
10		<u>N/A</u>			Pair	nter			Home :	[mpro	veme	nts
17. FATHER'S NAME (First, Mi							18. MOTHER'S NA	ME (First,	Middle, Maiden	Sumame)		
Harold A.	Walke	r					Dore	ene	Rowe			
19a. INFORMANT'S NAME (Ty	/pe/Print)			19b. MAII	LING ADD	RESS (Street a	nd Number or Rural	Route Nurr	nber, City or Tow	n, State, Zip	Code)	
Allen F. Wa	alker			704	47 K:	it Kat	Road, E	lkri	dge, M	1d.	2122	7
20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation		and from State				SPOSITION (Na		DAT	E 20c. LO	CATION -	City or To	wn, Stata
4 Donetion 5 Other		IOVALI ITOM: Statu	ceme	ruld l	31dge	e Ceme	tery	3/1	.0 Ba	ltimo	ore,	Md.
21. SIGNATURE OF FUNERAL	SERVICE LIC	CENSEE	5				D ADDRESS OF FA					
 //.		4	1									Elk., Inc.
23. PART I. Enter the di	W.	complications that	Carried d	mass	7	5695 M	ain St.,	_E1k	ridge.	Md.	21	
shock, or he	art fellure.	Liet only one caus	se on se	ch line.	JO HOL BI	mer ma mo	de of dying, suc	n as car	diac or resp	ratory arr	eat,	Approximate Interval Between
IMMEDIATE CAUSE (Findiseese or condition	el											Onaat and Death
resulting in death)	→	. METE	971	4TIC	CA	RCII	AMOL	OF	THE	Lu	NG	~ 1 YEAR
ľ		DUE TO	OR AS A	CONSEQUENC	E OF):							95 9 33 7
Sequantially list condition	ons.	b										
if any, leading to immed cause. Enter UNDERLY!	flate	DUE TO (OR AS A	CONSEQUENC	E OF):							
CAUSE (Disease or Injui		C										
that initiated evente resulting in deeth) LAST		DOE TO	OR AS A	CONSEQUENC	E OF);							
1207-11-11-11-11-11		d										
PART II. Other algnifices	nt condition	a contributing to	deeth bu	t not reculti	ng in the	underlying	ceuse given in	Part I.	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
		HRMA				1000			PERFOR			AMILABLE PRIOR TO COMPLETION OF CAUSE
		FRACTU			T 6	3711	~	_	1 TYES 2	NO		OF DEATH?
DID TOPACCO US	CE CONIT	DIBLITE TO CAL	ICE OF	DEATH	VEC E	72.M. U	LINICEDTAIN					1 TYES 2 NO
DID TOBACCO US		RIBUTE TO CAL		6. PLACE OF I			UNCERTAIN	ΝЦ				
EXAMINEM?	MEDICAL	HOSPITAL:		- 1.111	OTI	HER;						
1 VES 2 NO		1 npstlent 2					5 Residence					
_	Pending	28s. DATE OF I		28b.	TIME OF INJURY	28c. INJU WOI	RK?	28d. DE	SCRIBE HOW I	NJURY OCC	CURED	
	nvestigation	3/3/	75				ES 2 NO		FALL			100
	Could not be	28 PLACE OF building, a	INJURY -	- At home, fa	rm, atreet,	factory, office		28f. LOC City	Or Town, State)	and Number	or Rural R	oute Number,
4 Homicide d	letermined						- 38					
290. CERTIFIER (Check only	FYING PHYSI	CIAN: To the best of r	ny knowle	dga, death oc	curred at t	the time, data	and place, and due	to the ca	use(s) and mai	ner aa stel	ed,	
												and manner as stated.
29b. SIGNATURE AND TITLE						1	29c. LICENSE NUR					(Myinth, Day, Year)
Joka .	1. 7	Sullm.		MID		1	D 222			b	2/0	195
30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	E OF DEAT	TH (ITEM 27) /	Type, Print)	-	シスペム	40			101	//0
JOHN	S.	BRITT	_				EBNE S	TRA	LET, I	BALT	MO	RIE, MD
31. DATE FILED (Month, Day, Y		32. REGISTRAF							*			

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BALTIMORE, MARYLAND 21215-0020

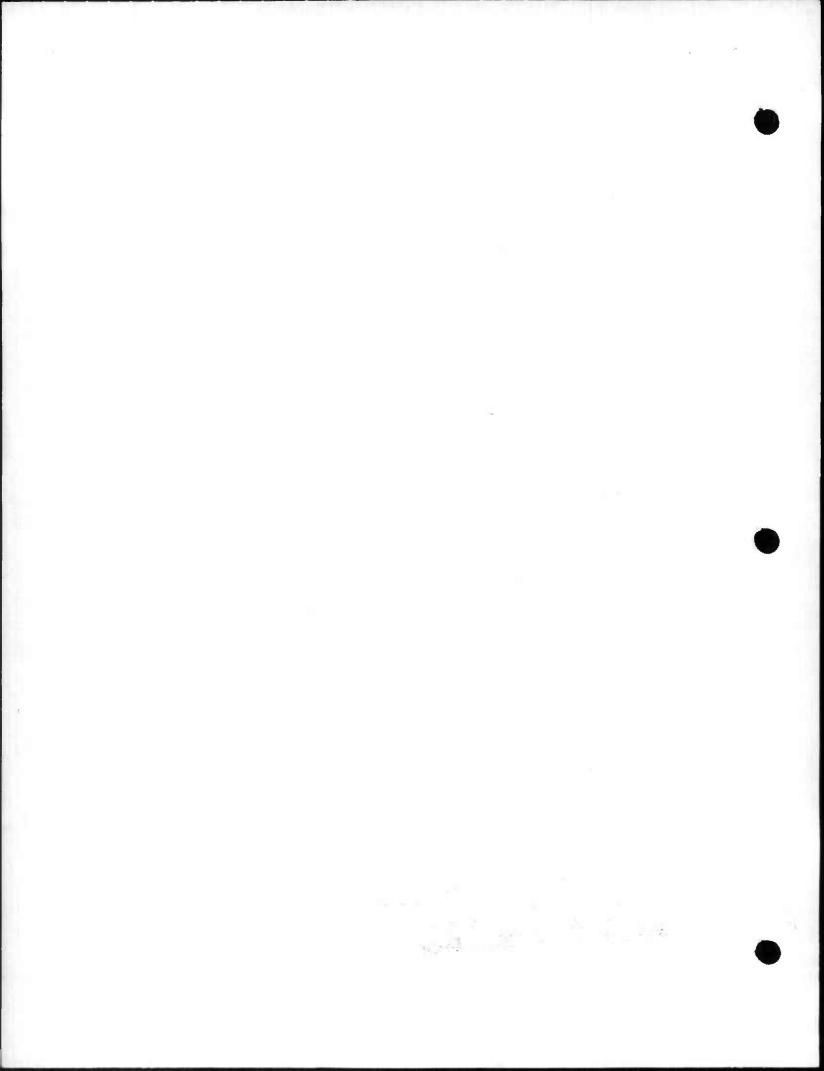
FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	1D				2. DATE OF	DEATHDAY	YEAR	3. TIME OF DEATH	
	JESSE E. WEBSTER,					MÄRCH		995 ^{YEAR}	2:05 p м	
	216-01-9597	1 M 2 - F	(In yrs. last birthday) 78 YRS.	MONTHS DAYS	HOURS MIN,	June	28 ,1 916	8. BIRTI	HPLACE (State or Foreign Tyland	
TOR	98. FACILITY NAME (If not institution, give str NORTH ARUNDEL HOS RESIDENCE OF DECEDENT		IATION	96. CITY, TOWN	URNIE	DEATH	1	A.COL		
DIRECTOR	10a. STATE 10b. COUNTY	e Arundel		y, town on Local sadena	TION				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 1950 North A	venue		16	of. ZIP CODE	21122	10g.	USA	WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 XNO	If yes, s	CENDENT OF HISP/ pecity Cuban, Mexic S 2 NO Spec	an, Puerto Rica	specity Yea or No n, etc.)	- 14. RAC	E — American Indian, ik, Whita, atc.	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of v life. Do NOT us	USUAL OCCUPATI vork done during me retired.)	ON ost of working	16b. KII	ID OF BUSINES	J/INDUSTRY		
MPL	8		Retired	Inspec	tor	W	estern	Electr	cic Co.	
BE CO	17. FATHER'S NAME (First, Middle, Lest) Jesse Ellsworth	Webster, S			16. MOTHER'S N Susie					
TO B	19a. INFORMANT'S NAME (Type/Print) Mrs. Alice R. We	bster	195. MAILING 1950	ADDRESS (Street North	and Number or Rura AVe., Pa	Route Number, Isadena	City or Town, State , Md .	21122	2	
	20a. METHOD OR DISPOSITION 1	val from Stata 20	ob. PLACE AND DATE Of the troin of the tro Cre			16/95	20c. LOCATION		own, State , Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICE		E. Ecker	22. NAME A MCCU	No ADDRESS OF E	ral Ho	me of F	asader	na	
NOI	23. PART I. Enter the diseases, or conshock, or heart fellure. Limited in the constant of the	DUE TO (OR AS	A CONSEQUENCE OF						Approximate interval Between Onset and Death	
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, laading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Last only on as a consequence of: Due to (or as a consequence of: Due to (
MEDICAL	PART II. Other significant conditions Anthu	un.					PERFORMED? YES 2 O'N		. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
AN.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
SICI		HOSPITAL:	26. PLACE OF DEAT	OTHER:	- 115-57					
PHYSICIAN:	27. MANNER OF OEATH 1 1 Natural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. tN.	JURY AT DRK? YES 2 NO	1		V INJURY OCCURED		
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	treet, factory, offic		281. LOCATIO City or To	N (Street and Numero, State)	mber or Rural F	Route Number,			
COMPLETED	29a. CERTIFIER (Check only one)									
8	29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of examinati	on and/or investigation	n, in my opinion, o			place, and due	io the cause(a	n) and manner as stated.	
TO BE	Heroliha	Redde	1		D3C	568	29d.		·13 ·95	
	30. NAME AND ADDRESS OF PERSON WHO SHOBHA D. REDDY, M	.D. 7845 OA	KWOOD ROA	D, #204	GLEN BU	RNIE, N	1ARYLAN	D 2106	1	
	MAR 1 4 1995	32. REGISTRAR'S SIG	NATURE							

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DIVISION OF VITAL RECORDS, P.O. BOX 68760



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TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

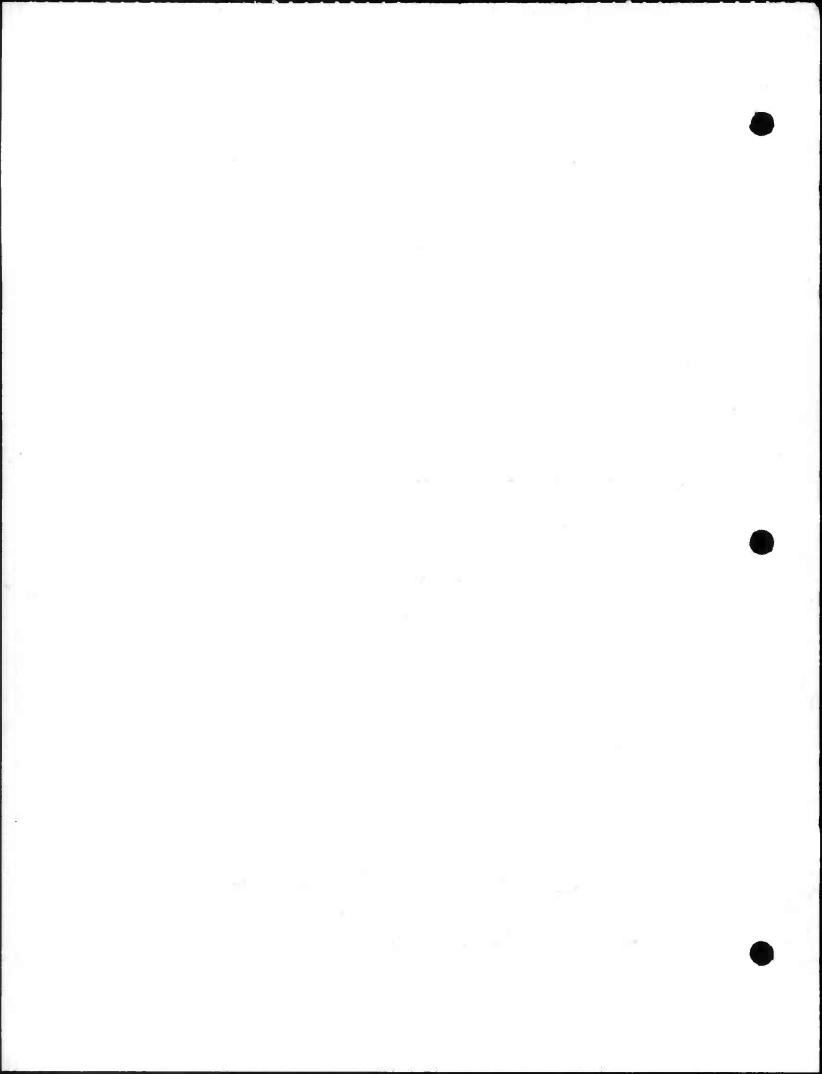
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM				YGIENE EG. NO.			
1. OECEDENT'S NAME (First, Middle, Last) MAY ELEANO.	RAWEBB		3		2. DATE OF D		YEAR 95	3. TIME OF OEATH	
	SEX 8. AGE (In		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BI	RTH (80°) 1926	8 BIRT	HPLACE (State or Foreign try) aryland	n
9s. FACILITY NAME (If not institution, give street Stella Maris RESIDENCE OF DECEDENT	· ·	9b.		R LOCATION OF DE	ATH	1	onty of the	tmore	
10a. STATE 10b. COUNTY	ltimore	10c. CITY, TO	OWN OR LOCATI	on Rosedal	Le			10d. INSIDE CITY LIMITS? 1 YES 2 XNO	
100. STREET AND NUMBER 7406 Meadow Br	anch Court		101.	ZIP COOE 2123	37	10g. CI	US	WHAT COUNTRY?	
	. WAS OECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	U.S. ARMED	If yes, spe	NOENT OF HISPAN cify Cuban, Mexices 2 XNO Specify	IIC ORIGIN? (Sp.	ecify Yes or No— atc.)	14. RAC	E — American Indian, k, Whita, etc.	
15. OECEDENT'S EDUCATI (Specify only highest grade con Elementery/Secondary (0-12)	ON spleted) college (1-4 or 5+)	16a, DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during mas	N t of working	16b. KIND	OF BUSINESS/II	IDUSTRY	111111111111111111111111111111111111111	
7th 17. FATHER'S NAME (First, Middle, Last)		Sales		16. MOTHER'S NAI		Retail Meiden Surname)			\dashv
William Kin 19a. INFORMANT'S NAME (Type/Print)	a	19b. MAILING ADD	DRESS (Street an	Flor		Stans		<u>Y</u>	\dashv
Florence Fultz 20a. METHOD OF DISPOSITION 1- Buriel 2 Cremation 3 Removal		LACE AND DATE OF DE	ISPOSITION (Nan			timore		. 21237 own, Stata	\dashv
4 Donation 5 □ Other (Specify) □ 21. SIGNATURE OF FUNERAL SERVICE LICENS	Ga	ery, cremetory or other pardens o	F Fai	th 3/13 paddress of Fac elly Fu	CILITY	Ross			\dashv
	OVARIAN C	ANCER (enter the mod	le of dying, such	h as cardiac o	or reaplratory a	rreat,	Approximate interval Betwoonset and De 3 years 6	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A C								
PART II. Other significant conditions of	ontributing to death but	not resulting in th	ne underlying	cause given in i		WAS AN AUTOPSY PERFORMEO? YES 2 NO	24b	WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	
DID TOBACCO USE CONTRIB				UNCERTAIN	<u> </u>			1 TES 2 NO	╝
EXAMINER?	OSPITAL: Inpatient 2 ER/Outpati 26s. DATE OF INJURY	lant 3 DOA 4 D	HER: Nursing Home	RY AT	6 Other (Spec	HOSP			\exists
1 Natural 5 Pending 2 Accident investigation 3 Suicide 8 Could not be	(Month, Day, Year) 28e. PLACE OF INJURY — building, stc. (Specify	At home, farm, street	M 1 🗆 Y	IK? ES 2 NO	28f. LOCATION	(Street and Numb		Route Number,	_
4 Homicide datarmined 29a. CERTIFIER (Check only 1 DEERTIFYING PHYSICIAN			the time date a	and place, and due	City or Tow		ato d		4
One) 2 MEDICAL EXAMINER: 0	n the basis of examination e	end/or investigation, in	my opinion, de	ath occured at the t	time, data and p	laca, and due to	the ceuse(i		1.
29b. SIGNATURE AND TITLE OF CERTIFIER ON A Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q	Faulk	All TEM 27 /500 CO	0	DA56	943	29d. DA	3///	(Month, Day, Year)	
2300 Du	ANEY U	A //EY	Rd;	Tows	ON	Md	2/2	204	
MAR 1 4 1995	Julia d'aucles								



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29b. SIGNATURE AND TITLE OF CERTIFIER

4 1995

ERRY

31. DATE FILED (Month, Day, Year)

thom

ANN

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HUNTER,

BE

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Flowers after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, burial than the burial Hygiene prior to burial, cremation, or removal.

95 07709 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH March Lacy 7:42A M 995 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yeer 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS DAYS HOURS 1 M 2 X VRS 476-16-1106 8, 1922 Wisconsin Jan. 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Howard County General Hospital Columbia Howard RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Columbia Howard 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5605 Tricross Drive 21045 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried ΒY Specify: 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) Medical Technologist 12 Federal Government 4 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Francis A. Harrington Marguerite Mahoney ш B 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code, 9 Marvin H. Ashley (Son-in-Law) 5605 Tricross Drive, Columbia, Md. 21045 20s METHOD OF DISPOSITION
1 X Burlet 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Mar. Garrison Forest Cem. cest Cem. 15, 1995 Owings Mills, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSE Leroy M. & Russell C. Witzke Funeral Home Reserved 5555 Twin Knolls Rd, Columbia, Md. 21045 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, ahock, or heert fellure. List only one ceuee on eech ilne. Interval Betwe IMMEDIATE CAUSE (Fine) Onset and Death disease or condition Pneumma reaulting in death) newer DUE TO (OR AS A CONSEQUENCE OF): Heart mplete 2 days CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING Pulmmary Disease CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events recuiting in deeth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Dealetes mellettes 1 YES 2 NO DF DEATH? 1 YES 2 JANO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 Dinpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 27, MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Mitturel
2 Accident NA Day, Year) М 1 YES 2 NO В Investigation 2 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER

(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated.

32. REGISTRAR'S SIGNATURE

Knoll

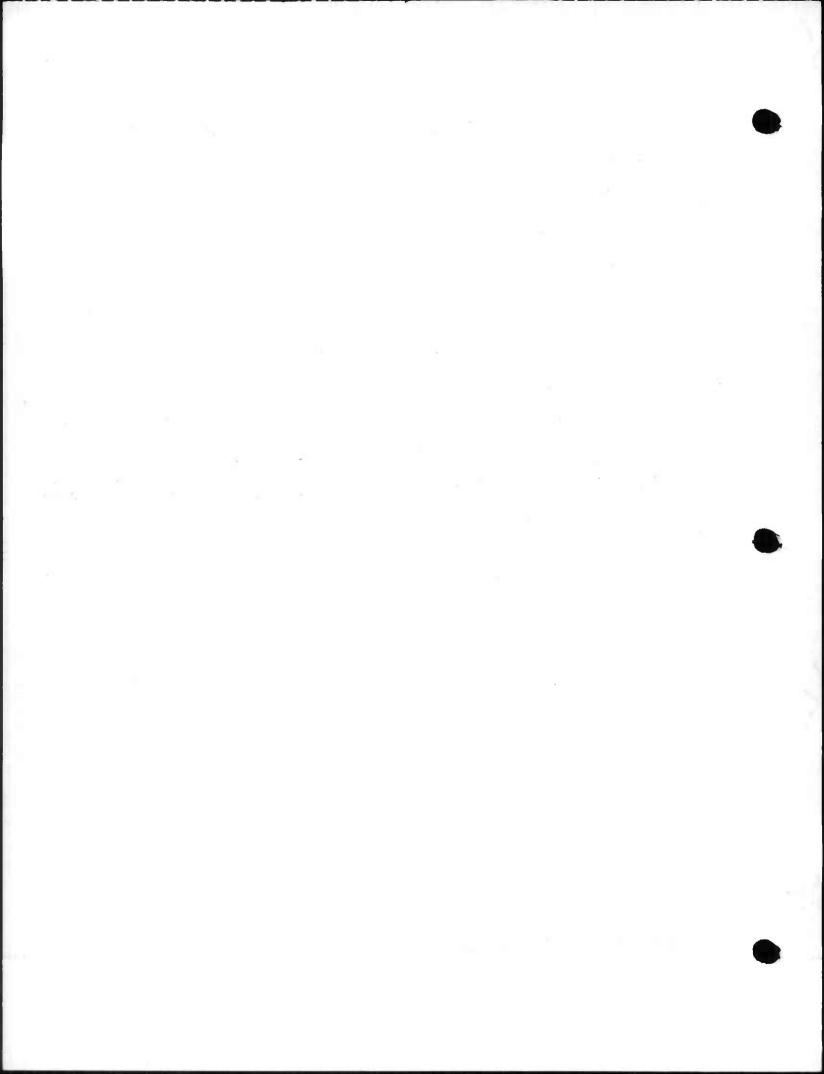
N ood

MO

29c. LICENSE NUMBER

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29d. DATE SIGNED (Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL	1
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1 - STATE REGISTRAR TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely flied in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DE COMB TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

_		CATE	OF DEATH	REG. NO		
	1. DECEOENT'S NAME (First, Middle, Lest) V1-911 B. Zook			2. DATE OF DEATH	7/95	YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NOMBER 5. SEX 6. AGE (In yrs. lest birthdey) 579 - 05-6767 1 M M 2 - F 8 / YRS.	IF UNDER 1 Y	EAR IF UNDER 24 HRS. AYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	L	8. SIRTHPLACE (State or Foreign Country) Indiana
on Display	Sa, FACILITY NAME (If not institution, give street and number) NEDSINGTON Gardens RESIDENCE OF DECEDENT	86. CITY, TO Ker	SINGTON	MO	9c. COUN	NTGOMERY
DIRECTOR	10e. STATE 10b. COUNTY 10c. CIT	ensi	,			10d. INSIDE CITY LIMITS? 1 YES 2 NO
UNEHAL	3000 MC Comas Ave		101. ZIP CODE	395	10g. CITIZ	ZEN OF WHAT COUNTRY?
BY	11. MARITAL STATUS 1 M Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 TO YES 2 NO IF YES, GIVE WAR OR DATES	If yo	DECENDENT OF HISPAN s, specify Cuban, Maxica YES 2 NO Specify	n, Puerto Rican, atc.)	or No-	14. RACE — American Indian, Black, White, atc. Specify:
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) IIIe. Do NOT us	vork done durir	ng most of working	16b. KIND OF BU		USTRY
5	17. FATHER'S NAME (First, Middle, Last)	12.011		ME (First, Middle, Meiden		00114
100	190. INFORMANT'S NAME (Type/Print) 191b. MAILING		EL	A 151	ERGI	44
2	ELIENBETH C. LOOK LO A	Bax (SI	reet and Number or Rural F	Coute Number, City or Tow	n, State, Zip	EN, W. V. 2545
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 4 Donetton 5 Other (Specify)	ther place)	N (Name of	OATE 20c, LO	CATION C	City or Town, State
1	21. SIGNATURE OF FUNERAC SERVICE DICENSES		ME AND ADDRESS OF FAC			
	23. PART I Enter the diseases or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF	onic	-			interval Between Onset and Death
2	Sequentially list conditions, if any, leading to immediate	า:				1979
5	CAUSE (Disease or injury	D.				1979
	that initiated events resulting in death) LAST	,				1979
7	PART II. Other significant conditions contributing to death but not resulting in	n tha under	lying cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDI				1 YES 2	No	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
314.		s X NC		10		7
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	QTHER:	one) Homa 5 🗆 Realdenca	8 (Other (Specify)		
	27. MANNER OF OEATH 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	E OF 280 URY	WORK? YES 2 NO	28d. OESCRIBE HOW II	VJURY OCC	UREO
	3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, ferm, a building, atc. (Specify)	treet, factory,	office	281. LOCATION (Street a City or Town, State)	ind Number	or Rural Route Number,
	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurre one)					
3	2 MEDICAL EXAMINER: On the basis of examination and/or investigation 29b. SIGNATURE AND TITLE OF CERTIFIER	rr, in my opini	29c_LICENSE NUM		d due to the	
	DBP atom IT M		DIT	729	▶3	13/95
		Print) ICSV	lle Rd	55, Md	20	910
	MAR 1 4 1995					

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

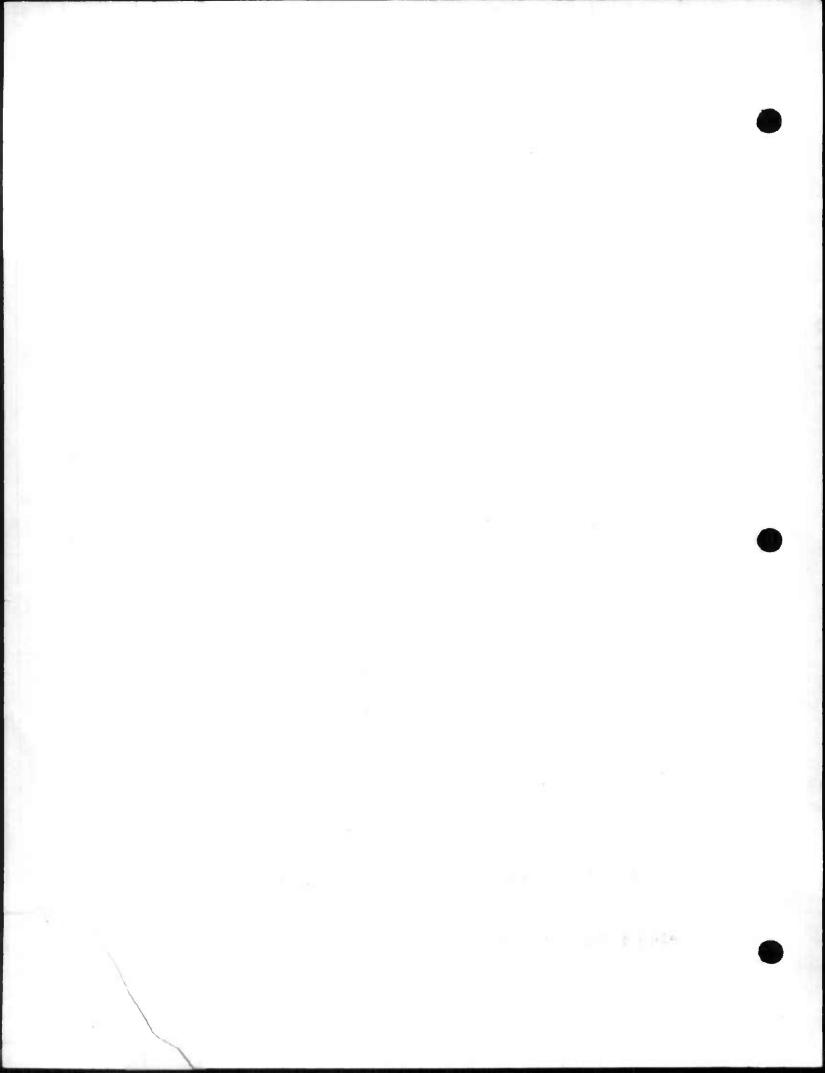
	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF I	IEALTH AND	MENTAL HYGIEN	E		
- 1	1. DECEDENT'S NAME (First, Middle, Last)				DEATH	2. DATE OF DEATH			3. TIME OF DEATH
	Joyce Myrtle	e	Zolman	ı		March 87	1995	YEAR	11:28 P
			yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			
- 8	213-52-2485	1 M 2 XF 47		MONTHS DAYS	HOURS MIN.	087167194	7 "	Country)	LACE (State or Foreign
- 8	9s. FACILITY NAME (If not institution, give atre								yland
œ					OR LOCATION OF DE		9c. COUNT		ATH
DIRECTOR	Johns Hopkins Bay	view Medical	CLL.	Dall	imore Ci	Ly	IN,	/A	
B	10a. STATE 10b. COUNTY		10c, CITY.	TOWN OR LOCA	TION				10d. INSIDE CITY
뜻	Maryland	Baltimore			Dund	alk		- 1	LIMITS?
	10e. STREET AND NUMBER	DATCHINIC		140	. ZIP CODE	W117			TES 2 KNO
2	1405 Vesper Avenue			"		222			States
FUNERAL		12. WAS DECEDENT EVER IN							
	1 Never Married 2 Married	FORCES? 1 TYES	2XX10	It yes, ap	ecify Cuban, Maxica	IIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No- 1	4. RACE - Black,	- American Indian, White, stc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	res	1 TYES	2 NO Specifi	y:		Specify.	White
	16. DECEDENT'S EDUCA	TION	16a. DECEDENT'S U	SUAL OCCUPATION	NI .	THE WHID OF BUILD			
Ë J	(Specify only highest grade co	ompleted)		rk done durina mo		16b. KIND OF BUS	SINESS/INDU	STRY	
2	Elamentery/Secondary (0-12) 1.2 Years	College (1-4 or 5+)		rk Typi	ct	Cleri	cal		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		CIE	TK TABT					
						ME (First, Middle, Maiden			
BE	Richard T. Zolman					le V. Bowe			
2	19s. INFORMANT'S NAME (Type/Print)					Route Number, City or Town			2.0
- 1	Ceorge R. Zolman		<u> 831</u>	9 Patar	sco Road	Pasadena	, MD	211	22
	20a. METHOD OF DISPOSITION NXBuriel 2 ☐ Cremation 3 ☐ Remov.	al from State come	LACE AND DATE OF	DISPOSITION (Na	me of	OATE 20c. LO	CATION — CH		
	4 Donation 5 Other (Specify)	Pa	rkwood C	emetery	3/13/9	5 Ba	ltimo	re,	MD
ţ	21. SIGNATURE DIFFUERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk								
	1 hala	1 +							
	23. PART I. Enter the diseases, or co	molications that opposed	The ferror David	1922	wise Ave	. Dundalk	, MD	212	
ı	ahock, or haart fallure. Lie	st only one cause on age	ch ilna.	t anter tha mo	da or dying, suc	n aa cardiac or reapi	ratory arrea	st,	Approximata Interval Between
ľ	IMMEDIATE CAUSE (Final disease or condition								Onset and Death
	resulting in death) a. Reliai Fallure							l week	
	OUE TO (OR AS A CONSEQUENCE OF):								
z I	Sequentially list conditions, b.	Sepsis							l week
ĔI	if any, laading to immediata	OUE TO (OR AS A C	CONSEQUENCE OF):						
CERTIFICATION	CAUSE (Disease or Injury	AUSE (Disease or Injury							
	that initiated events	OUE TO (OR AS A C	ONSEQUENCE OF):						1 month
	resulting in death) LAST								
- 11	PART II. Other significant conditions	contributing to death but	t met moultime to	After the dealers					
Ŋ.	Train in Other Significant Conditions	contributing to death bu	t not resulting in	tha undariying	cause given in	Part I. 24a. WAS AN PERFOR		A	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO
ă	CO								OMPLETION OF CAUSE OF DEATH?
Ž								1	YES ZY NO
ž I	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAIN	1 2			
<u> </u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		B. PLACE OF DEATH						
	1 YES 2 NO 1	Inpetient 2 ER/Outpet		OTHER:	5 Residence	8 Other (Specify)			
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28s. DATE OF INJURY	26b. TIME	OF 28c. INJ	URY AT	28d. DESCRIBE HOW IN	JURY OCCUI	REO	
BY	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJUE		RK? ES 2 NO				
- 40	2 Sulate	28s. PLACE OF INJURY -	- At home, farm, stre			28t. LOCATION (Street a	nd Number or	Rumi Bou	da Number
	4 Homicide 8 Could not be datermined	building, stc. (Specif)	()	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, State)	na rumon or	riurar riou	ne nomber,
9	29s. CERTIFIER								
COMPLET	(Check only	AN: To the best of my knowled							
2	2 MEDICAL EXAMINER:	On the basis of examination :	and/or investigation,	In my opinion, d	eath occured at the	time, data and place, and	due to the o	cause(s) s	ind menner as stated.
H H	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN	BER	29d. DATE S	SIGNED (N	forith, Day, Year)
	Mulo 7				AF21/164	200-157			9,1995
2	30. NAME AND AODRESS OF PERSON WHO	COMPLETEO CAUSE OF DEAT	H (ITEM 27) (Type, P	rint)					
	G. Diko MA		John	s_Hopki	ns Bayvi	ew Medical Baltimore.	Cente	er	.
ŀ	31. OATE FILEO (Month, Day, Year)	32. REGISTRAR'S IGNAT		Faster	n Ave.	Baltimore,	MD 2	21224	1
	MAR 1 4 1995 july	34. REGISTRAR'S GIGNAT	Ц						
	111111 1111 1								

DIVISION OF VITAL RECORDS, P.O. BOX 68760

after death. Page 6 may be retained by the hosp	by the funeral director, page 5 should be detached	moval.	ical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
10 TH	TO TH	be file.	IMPO

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGIS THAN		CE	HILL	CALE	JF DEA	IH	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)						2	DATE OF E	DEATH	W	YEAR	3. TIME OF DEATH
	Henry Wilme						1	March				9:45 P. M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lea				y) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTY MONTHS DAYS HOURS MIM. (Month, Day, Ye						8. BIRTHE Country	PLACE (State or Foreign
	217-09-7205	1 💢 M 2 🗌 F	74	YRS.		, o moons	1	May 1		20		yland
or	9a. FACILITY NAME (If not institution, give s					VN OR LOCATI				9c. COUN	TY OF DE	ATH
DIRECTOR	4425 Hamilton	Avenue			Ва	ltimor	e Cit	У		1	N/A	
E C	10a. STATE 10b. COUNTY	,		10c. CITY	TOWN OR L	CATION						10d. INSIDE CITY
E	Maryland N/A					imore	City					LIMITS?
	10a. STREET AND NUMBER				Dare	10f. ZIP COD				ton CITI		Y YES 2 NO
R	4425 Hamilton	Avenue					206				S.A.	HAI COUNTRY?
FUNERAL	11. MARITAL STATUS		VER IN U.S. ARI	MED	13 WAS	DECENDENT O		OBIGIN2 (S-	anthi Man			A t t t
	1 Never Married 2 🔀 Married	12. WAS DECEDENT E FORCES? 1 A IF YES, GIVE WAR	YES 2 N	0	If yes	, specify Cube YES 2 1 NO	n, Mexicen, F	Puerto Rican	, etc.)	01 NO.		— American Indian, White, etc.
B	3 Widowed 4 Divorced		II		''	1E3 2 NO	<i>Specify:</i>				Specify	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DE0	CEDENT'S L	SUAL OCCU	ATION		16b. KtN	D OF BUS	INESS/IND	JSTRY	
91	Elementary/Secondary (0-12)	College (1-4 or 5+)				most of working	9			ehicl		
M	12th Grade		Lic	ense	Exami	ner		Adm	inis	trati	on	
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTI	HER'S NAME					
BE	George Wilmer	r Zorbach						Julia				
2	19a. INFORMANT'S NAME (Type/Print)					et and Number						
	Ann May Zorbach						enue, I	Baltin				-21206
	20a, METHOD OF DISPOSITION 1 C Buriet 2 Cremetton 3 Remo	oval from Stata	20b. PLACE A cemetery, crer	ND DATE O	F DISPOSITION Her place)	(Name of Memoria	-	DATE		CATION — C		
	4 Donation 5 Other (Specify)	ENCEE	Dulane	ey va				3-15				ryland
	N - 1	1	1	1		E AND ADDRES						r Road
_	" northlew	n. Mu	uph	4								MD21206
	23. PART I. Enter the diseases, or of shock, or heart feilure.	complications that co	on each line	th. Do no	ot enter the	mode of dyl	ng, auch a	a cerdiac	or reapli	ratory arre	eat,	Approximete
	IMMEDIATE CAUSE (Final	and only one outgo	0									Interval Between Onset and Death
1	disease or condition reaulting in death)		T	Losz	E	ancan						124
		DUE TO (OF	AS A CONSEO	UENCE OF)	:				_			
NO	Sequentially list conditions,	DUE TO 100	AS A CONSEQ									
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DOE TO (OR	AS A CONSEQ	UENCE UF	:							
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR	AS A CONSEO	UENCE OF	:							
E	resulting in deeth) LAST											İ
R												
EDICAL	PART II. Other aignificent conditions	s contributing to de-	eth but not re	suiting in	the under	ying cause g	given in Par	rt i. 24a.	WAS AN A			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
음								_ 1 [YES 2	4		COMPLETION DF CAUSE OF DEATH?
M								_				1 TES 2 NO
ä	DID TOBACCO USE CONTR	RIBUTE TO CAUS	E OF DEAT	H YES	NO	☐ UNC	ERTAIN				1	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE		(Check only o	ne)					-	
YS	1 TYES 2 NO	1 Inpetient 2 EF				iome 500 Ra	aldenca 8	Other (Spe	iclfy)			
	27. MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF INJ (Month, Day, 1	URY (bar)	28b. TIME INJU	RY	INJURY AT WORK?		d. DESCRIB	E HOW th	JURY OCC	JRED	
À I	2 Accident Investigation	200 01 405 05 10	Himy As A			YES 2						
<u>E</u>	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF IN building, etc.	(Specify)	ne, Tarm, st	reet, factory, o	ffica	28	Bt. LOCATION City or Tow		nd Number o	or Rural Ro	ute Number,
iii I	29g. CERTIFIER					-						
힐	1 L DOEDTIEVING DUVON	CIAN: To the best of my										
				rveatigetion	, in my opinio	n, death occur	ed at the time	e, data and p	placa, and	dua to the	cause(a)	and manner as stated.
g	2 MEDICAL EXAMINES		ination and/or in									
BE COMPLETED			nation and/or in			29c. LICE	NSE NUMBE	R				Month, Day, Year)
H	29b. SIONATURE AND TILE OF CERTIFIER	3: On the basis of exami	Rhyre	can		29c. LICE	17 17	R				
- 11	29b. SIONATURE AND THE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WAS	Or the basis of exami	Abyle OF DEATH (ITEM	27) (Type, 1	Print)	29c. LICE	100	R	B.			
H	29b. SIONATURE AND THE OF CERTIFIER 29b. SIONATURE AND THE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WAS MILMAZL ATTOR	Staff COMPLETED CAUSE TYBV M	PRATH (ITEM	can	Print)	29c. LICE	100	r Ve	RAV			Month, Day, Year)
BE	29b. SIONATURE AND THE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WAS	Or the basis of exami	PRATH (ITEM	27) (Type, 1	Print)	29c. LICE	100	R Ve	Rai			



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. PORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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30. NAME AND ADDRESS LA ROBERT - B 31. DATE FILED (MONTH, DBY, MAR)

MD

^{year)} 2 1995

		FOR 1 STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR	TMENT O	F HEALTH A	AND M			70	0///3
Г		1. DECEDENT'S NAME (First, Middle, Last)		C	ERITE	ICATE	JF DEAI	-	REG. NO).		
			Devil 1 - March AT MONT									3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER							Feb. 28	1995		0130 KIN
			Attended to the second	(In yrs. les		MONTHS DA		MIN.	7. DATE OF BIRTH (Month, Day, Year)		Count	HPLACE (State or Foreign
		410 30 1137	1 □ M 2 💢 F	86	YRS.				Oct. 9 1	908	Ma	ryland
ı	~	9e. FACILITY NAME (If not institution, give stre				9b. CITY, TO	WH OR LOCATIO	N OF DEAT	Ή	9c. COL	INTY OF C	DEATH
	0	17434 Virginia Av	enue			На	gerstov	wn		Wa	shin	gton
	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY										
- 1	2				10c. CIT	Y, TOWN OR L						10d. INSIDE CITY LIMITS?
			ington		L	Hager	stown					1 YES 2 NO
	M	10e. STREET AND NUMBER					101. ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?
	FUNERAL	541 Frederick Str	eet					217	40	U.S	.A.	
	5		12. WAS DECEDENT EVER	IN U.S. AR	MED	13. WAS	DECENDENT OF	HISPANIC	ORIGIN? (Specify Ye	s or No—	14. RAC	E — American Indien, k, White, etc.
	BY	1 Never Married 2 Merried	FORCES? 1 YES		10			, Mexican, I Specify:	Puerto Rican, etc.)		Spec	
		3 Widowed 4 Divorced									Wh	ite
	9	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION propleted)			USUAL OCCU	PATION most of working		16b. KIND OF BU	SINESS/IN	DUSTRY	
	Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ho.	Do NOT us	e retired.)	I most or working	,				
of .	를	Unknown	0		Home	maker			Her	own h	ome	
once	COMPL	17. FATHER'S NAME (First, Middle, Last)			- -		18. MOTHE	ER'S NAME	(First, Middle, Meiden			
75	BE	Truman Leo Wolfe					Ali	ice M	innie Key	zfany	P	
		19e. INFORMANT'S NAME (Type/Print)		198	. MAJLING	ADDRESS (Str			ite Number, City or Tow			
100	٤	Richard Alton										217/0
9		20a METHOD OF DISPOSITION										
nust		1 Donation 5 Other (Specify)	ral from State CA	metery, crei	metory or of	her place)		2 2				
10		21. SIGNATURE OF FUNERAL SERVICE LICE		oons	boro	Cemete		3-3-				Maryland
medical examiner must		. 6 . 0	an i		4		E AND ADORESS		TITITITE			1 Home
. S		2000 Milliannick 415 E. Wilson Blvd. Hagerstown, Md. 21740										
leal		23. PART I. Enter the diseeses, or co	mplications that ceuse	d the de	eth. Do n	ot enter the	mode of dyln	g, such a	a cardiac or reap	iratory er	rest.	Approximate
3	- 1	Shock, or neart fellure. Li	st only one cause on	each line.	00		,	0	<u> </u>	,	,	interval Batween
1		IMMEDIATE CAUSE (Final disease or condition	Donte	> /	100	Caro	id	1.	forct	2		Onset and Death
H,		resulting in death) a.	14001	-	40	COUNC	100	M	Janel	(en		Simerco
or other traumatic event,		1	Delas.	- Congeo	Z.	1	923	03	× -/	7		
at a	8	Sequentially list conditions, b.	DUE TO COD AS	A CONTRA	MIC	600	oney	cou	ay ou	sur		
a E	ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEC	UENCE OF):	(Υ			
	일	CAUSE (Disease or injury & c.	DUE TO COD AS									
oth	Ē	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQ	DENCE OF	j:						
		d.										
	- 1	PART ii. Other eignificent conditione	contributing to deeth	but not re	eulting in	n the underl	ying ceuee giv	ven in Pe	rt i. 24a, WAS AN	AUTOPSY	246	. WERE AUTOPSY FINDINGS
shows any Inj	EDICAL								PERFOR	-	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE
20									_ 1 🗆 YES 2	-NO		OF DEATH?
è è	Σ	DID TODA CCO HET COLUMN							_			1 NES 2 NO
23	SICIAN	DID TOBACCO USE CONTRI	BUTE TO CAUSE C					RTAIN				
Item	ਹੇ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACI	OF DEAT	OTHER:	ine)					
5	<u>s</u>	1 NES 2 NO	□ Inpatient 2 □ ER/Out	patlant 3	□ DOA		iome 5 Presi	dence 8	Other (Specify)			
	PHY	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)		28b. TIME		INJURY AT WORK?	26	d. DESCRIBE HOW I	NJURY OC	CURED	
- 34	B	1 Natural 5 Pending 2 Accident Investigation					YES 2	NO				
90		3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spe	Y — At hon	ne, term, s	lreet, factory, o	ffice	26	St. LOCATION (Street a	and Number	or Rural F	Route Number,
N	ETE	4 Homicide determined		,					City or Town, State)			
		29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the beat of my know	vledge des	th occurre	d at the time	fete and place :	and dura to	the leavestable and	ALCHE EX		
	COMP		On the besis of examination									and manner on stated
M	3	6/ 4			M	,y opinio						
		296. SIGNATURE AND TITLE OF CERTIFIER	1 1/2	ou 1	MA	Him	29c. LICEN	ISE NUMBE	R	29d. DAT		(Month, Day, Year)
₹ .	2	20 NAME AND DOUBLE OF THE PARTY OF	15-40	corge	117	VCIan	1)(04:	359	_	3/2	195

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without or after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH				
	LEAH EDNA	AMBROS	E				4 95	2:06a M		
- 8	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		IRTHPLACE (Stells or Foreign ountry)		
	199-07-7061 1 9e. FACILITY NAME (If not institution, give street	M 2 F 95	YRS.	Sh CITY TOWN C	PR LOCATION OF DE	(Month, Day, Year) 7-17-18	99 WA	SHINGTON CO		
DIRECTOR	WASHINGTON COUNTY HOSPITAL HAGERS					-AIR	WASHI			
E E	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d, INSIDE CITY		
HIC	MD Washi	ington	L	7illiams	port			LIMITS?		
	100. STREET AND NUMBER				ZIP CODE		10a. CITIZEN (OF WHAT COUNTRY?		
FUNERAL	16500 Village Avenue				21795			SA		
3		U.S. ARMED	U.S. ARMED 13. WAS DECENDENT OF HISPAN				RACE — American Indian,			
F	1 Never Married 2 Merried	2 ☑ NO If yee, specify Cuben, Maxices TES 1 ☐ YES 2 ☑ NO Specify			n, Puerto Rican, etc.)	1 8	Black, White, etc.			
84	3 Widowed 4 Divorced	x					White			
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ON npleted)	18e. DECEDENT'S U	ork done durina mo		16b. KIND OF BUS	SINESS/INDUSTF	tγ		
		College (1-4 or 5+)	life. Do NOT use		THE SECTION AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS					
₹	12 2	2 Sales Cle					ng Sto	re		
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden				
H	Charles E. Scadder	l	1			eth Bowers				
2						Route Number, City or Tow.)		
	Shirley C. Soltis	- I m	II.3253 F		head RD	Hagersto	OWN MD	21742		
	NXBuriel 2 Cremation 3 Removal 4 Donetion 5 Other (Specify)	from State came	tery, cremetory or oth	er plece)						
	A COMPTINE OF FINISH OFFICE OF STREET						CO., MD			
	D D D	\ \						l Home, INC		
-	James (1)	taclerox		50 S.	Broad S	T Waynesbo	oro PA	17268		
	23. PART I. Entar the diseases, Dr CDm ahock, Dr heart fallure. List	Dnly Dna cause Dn aa	ch lina.	it antar the mo	da of dying, suci	h as cardiac or reapi	retory arrest,	Approximate interval Between		
	IMMEDIATE CAUSE (Final disease or condition type at a cayandon to the care of the cayandon type at a cayando							Onset and Death		
	resulting in death) a. VIRAL SYNDROME DUE TO (OR AS A CONSEQUENCE OF):							4DAYS		
_			.,,					İ		
CERTIFICATION	Sequentially list conditions, If any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):									
CA	CAUSE (Disease or Injury									
E	that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)	:						
#	d									
AL 0							24b. WERE AUTOPSY FINDINGS			
S	Coronary Artery Disease, Arteiosclorosis				1 YES 2	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MEDIC	Hypertensive Cardiovascular Disease					1 YES 2				
ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
절	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
YSI	1 VES 2 NO	Inpetiant 2 - ER/Outpe			5 Residence	8 Other (Specify)				
표	27. MANNER OF DEATH	(Month, Day, Year)	28b. TIME INJU	RY WO	JRY AT RK?	28d. DESCRIBE HOW II	NJURY OCCURE			
à	1 X Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined determined				ES 2 NO					
				eet, factory, office	'	28f. LOCATION (Street e City or Town, State)	eet end Number or Rural Route Number, tate)			
COMPLETED	DO. CENTIFIED									
₩.	(Check only one) 2 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end piece, end due to the ceuse(s) end manner as stated. 2 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end piece, end due to the ceuse(s) end manner as stated.									
8	MEDICAL EXAMINES On the basis of examination and/or investigation, in my opinion, death									
닒	29b. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NUM			29d. DATE SIGNED (Month, Day, Year)		
၉	30 NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Save 1	Print)	D2680	ь	2	2/24/95		
					00000	MD	017/0			
	Allen W. Ditto 31. DATE FILEO (Month, Day, Year)	747 Nort	nern A	ve. H	agersto	wn MD	21742			
	FEB 2 7 1995	FEB 2 7 1995 32. PEGISTBAR'S SIGNATURE THE DESCRIPTION OF THE PROPERTY OF TH								
		V								

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BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

permit.

burial-transit

DIRECTOR

FUNERAL

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CERTIFICATION

PHYSICIAN: MEDICAL

BY

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2 1995

31. DATE FILED (Month, Day, Year)

SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Saudiar

HVP.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death, Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
NDING	R. After	er death	is ma
ATTE	RECTOF.	rs afte	ш 28
AL OR	AL DIR	2 hou	If iter
SPIT	NERA	thin 7	NE
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10	101	De de	IMP

95 07715 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MARCH ARY ATWELL Du 4. SOCIAL SECURITY NUMBER S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 M 2 M F HOURS 215-09-5156 76 07-01-1918 MD 9s. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harford Memorial Hospital Havre de Grace Harford RESIDENCE OF DECEDENT 10b. COUNTY 10e. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Harford Havre de Grace 1 X YES 2 NO 10e. STREET AND NUMBER 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 630 Linden Lane 21078 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, stc.)
1 □ YES 2 ☑ NO Specify: 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 3 X Widowed 4 Divorced White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roy K. Whitney Nellie M. Strong 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert K. Whitney 855 Ontario St., Havre de Grace, MD 21078 20a, METHOD OF DISPOSITION
1 ☑ Burtal 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Angel Hill Cemetery 4 Donation 5 Other (Specify) _ 3/4 Havre de Grace MD 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. 100 va 511 Havre de Grace, MD 21078-3197 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory errest, Approximate shock, or heart fallure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Finel Onset end Death 4 Mil CHEMIL disease or condition awm m mu 1500019 resulting in death) DUE TO (OR AS A CONSEQUENCE OF) 14056PS14 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, lesding to immediate ceuse. Enter UNDERLYING CAUSE (Disesse or Injury DEMINITIF DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part !. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 24e WAS AN AUTOPSY 1 - YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 | X Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 TES 2 ND 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, building, etc. (Specify) 3 Suicide street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, § City or Town, State) 6 Could not be City or Town, State) 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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DHMH-18 Rev 1/89

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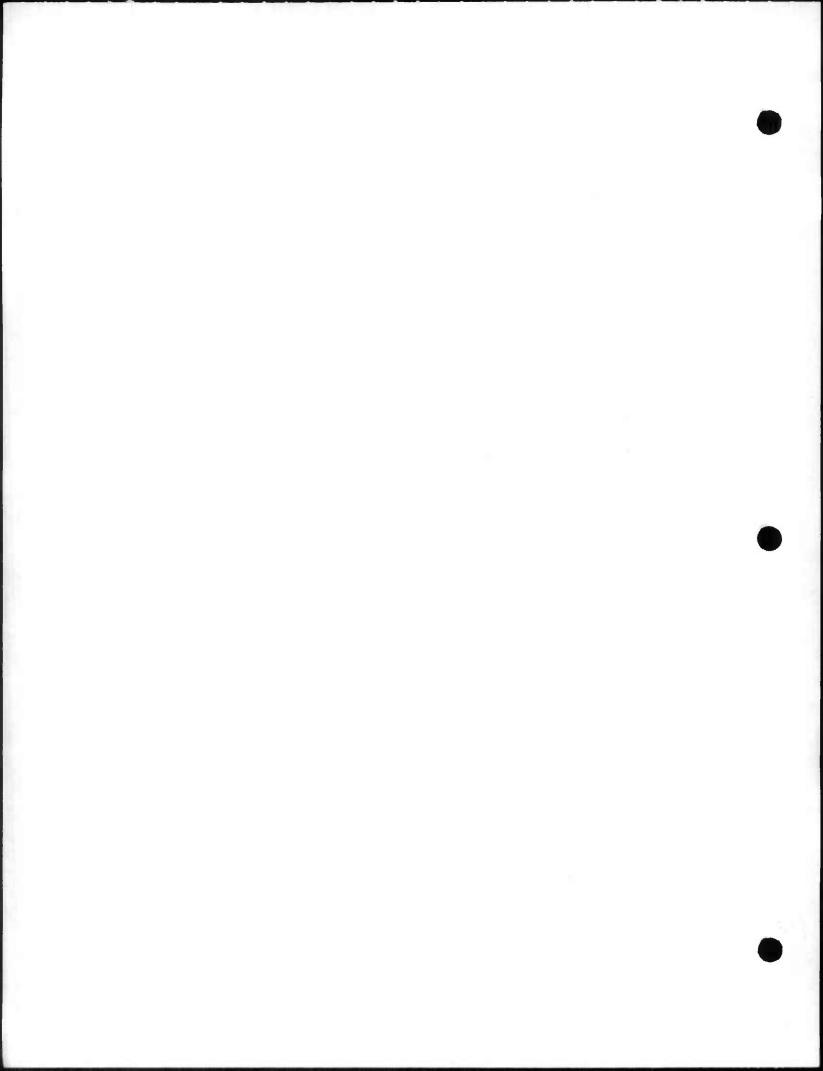
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached in the filled within 72 hours after death with the State Dent, of Health and Mental Hydiene prior to burial cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury or other traumatic event, the medical examiner must be notified at once
2	2 2	1

20b. PLACE AND DATE OF DISPOSITION (Name of Columbus, Ohio 20b. PLACE AND DATE OF DISPOSITION (Name of Columbus, Ohio 20b. PLACE AND DATE OF DISPOSITION (Name of Columbus, Ohio 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 220. PLACE AND DATE OF DISPOSITION (Name of Columbus, Ohio 221. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 2090 23. PART I. Enter the diseases, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, Interval disease or condition 1 DATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						
DECEMPT'S NAME (Free, Michigo, Last) Dr. Frank Hardee Allen Dr. Frank Hardee Allen Dr. Frank Hardee Allen Dr. Frank Hardee Allen Dr. Frank Hardee Allen S. SEX						
4. GOCIAL SECURITY HAMBER AND 192 S. SEX S. AGE (in yr. Last birmhopy F. MORTH F						
BOOD BY SEARCHTY MAKE (First immediate great i						
Secondary of black 1900 1918 1900 1918 1900 1918 1900 1918 1900 1918 1900 1918 1900 1918 1900 1918						
106. STREET AND NUMBER 309 Lantern Drive 106. CITIZEN OF WHAT COUNTR 3090 Lantern Drive 107. ZPC CODE 20902 USA 1.1 MARIAL STATUS 1.1 Mever Merried 2 [2] Merried 3 Widowed 4 Divorced 1.2 WAS DECEMENT EVER IN U.S. ARMED 1.3 WAS DECEMENT OF HIPPAINC ORIGIN? (Specify Yee or No 1 Process? 1 Yes 2 (2) NO From the Second) 1.5 DECEMENTS EDUCATION (Specify orly highest grade completed) 1.5 DECEMENT'S EDUCATION (Specify orly highest grade completed) 1.5 DECEMENT'S EDUCATION (Specify orly highest grade completed) 1.5 DECEMENT'S NAME (First, Middle, Last) 1.7 FATHER'S NAME (First, Middle, Last) 1.8 MOTHER'S NAME (First, Middle, Last) 1.9 MOTHER'S NAME (First, Middle, Last) 1.9 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Last) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan) 1.0 MOTHER'S NAME (First, Middle, Malsien Summan, Malsien, Pastern Summan, Malsien, Pastern Summan, Malsien, Pastern Summan, Malsien, Pastern Summan, Ma						
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16. DECEDENT'S EDUCATION 160. KIND OF BUSINESS/INDUSTRY 160. KIND OF BUSINESS/INDUSTRY 160. MIND OF BUSINESS/INDUSTRY 160.						
Prank Barton Allen Anniemae Esterling 19a. INFORMANT'S NAME (Pype/Print) Mary T. Allen D. Allen Drive, Silver Spring, MD 20902 20e. METHOD OF DISPOSITION 10 Suries 2 Cremetion 3 Removal from State Press Drives Columbus, Ohio 20e. METHOD OF DISPOSITION 10 Suries 2 Cremetion 3 Removal from State Press Drives Columbus, Ohio 20e. METHOD OF DISPOSITION 10 Suries Cremetion 3 Removal from State Press Drives Columbus, Ohio 20e. METHOD OF DISPOSITION 10 Suries Cremetion 3 Removal from State Press Drives Columbus, Ohio 20e. METHOD OF DISPOSITION 10 Suries Cremetion 3 Removal from State Press Drives Columbus, Ohio 20e. METHOD OF DISPOSITION 10 Suries Cremetion 3 Removal from State Profess Drives Columbus, Ohio 20e. METHOD OF DISPOSITION 10 Suries Cremetion 3 Removal from State Profess Drives Columbus, Ohio 22. NAME AND ADDRESS OF FACILITY 12 Francis J. Collins Funeral Home, Inc. 12 Suries Collins Funeral Home, Inc. 12 Suries Cremetion Suries Collins Funeral Home, Inc. 12 Suries Cremetion Suries Cremetion Suries Cremetion Suries Collins Funeral Home, Inc. 12 Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetion Suries Cremetics Columbus, Ohio 22 NAME AND ADDRESS CREMETION Suries Cremetion Suries Cremetics Columbus, Ohio 22 NAME AND ADDRESS CREMETION Suries Cremetion Suries Cremetics Columbus, Ohio 22 NAME AND ADDRESS CREMETION Suries Cremetion Suries Cremetics Columbus, Ohio 22 NAME AND ADDRESS CREMETION Suries Cremetion Suries Cremetics Cremetics Cremetics Columbus, Ohio 22 NAME AND ADDRESS CREMETION Suries Cremetics Crem						
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198. INFORMANT'S NAME (NyperPrint) Mary T. Alien G. Alle						
Mary T. Allen 3909 Lantern Drive, Silver Spring, MD 20902 20e. METHOD OF DISPOSITION 10 Burdel 2 Cremetton 3 Removal from State 4 Denatton 4 Other Places 4 Denatton 5 Other Places 4 Denatton 5 Other Places 500 University Blvd.W. Sil.Spr.MD 2090 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 2090 23. PART I. Enter the diseases, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, interval disease or condition resulting in death) Approximately list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Place downts resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						
20b. PLACE AND DATE OF DISPOSITION (Name of aprention) and provided an						
23. PART I. Enter the diseases, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, above, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						
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DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if arry, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.						
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u dd.						
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PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPS						
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 1 YES 2 NO 1 YES 2						
1 YES 2						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)						
28. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO 1 inpetient 2 EX/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify)						
I 27. MANNER OF DEATH 266. DATE OF INJURY 26b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED						
m 2 Accident Investigation M 1 YES 2 NO						
3 Suicide 6 Could not be 4 Homicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State)						
29s. CERTIFIER (Check only one) 1 \(\times \) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 \(\times \) MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner ee stated.						
O MAN SIGNATURE AND TITLE OF SECURITIES						
m // A						
March 1, 19						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typ. Print)						
March 1, 19						



f	mended #21 FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	95 DEPART ERTIFIC	MRT MENT OF I	HEALTH AND	MENTAL HYGIEN REG. NO	95 Ery	Co	unty
	1. DECEDENT'S NAME (First, Middle, Last) Ludmila Anderson					2. DATE OF DEATH DAY OF DEATH OF DEATH OF DEATH OF DEATH			
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. les		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Pay, Year)	-		ACE (State or Foreign
	214-33-1460 1 9a. FACILITY NAME (If not institution, give street	end number)			OR LOCATION OF D	09/12/10	7		RUSSIA
CTOR	Montgomery Gener				4.13	832		rtgon	
DIRECTOR	MD 100. STATE 100. COUNTY MONTG	omery		TOWN OR LOCA Kuille,		853			d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	15415 13: Herroot	Way		10	1. ZIP CODE	72			T COUNTRY?
O.	t1. MARITAL STATUS 12	. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2	MED	13. WAS DEC	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Maxican, Puerto Rican, etc.)			RUSS	American Indian,
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES	10		2 X ND Specif			Black, W Specify:	WHITE
9	15. DECEDENT'S EDUCATI (Specify only highest grade con	opleted) (Gi	CEDENT'S US ive kind of wor Do NOT use	SUAL OCCUPATION OF THE MENT OF	ON ost of working	16b. KIND OF BU	SINESS/INDU	STRY	
COMPLETED	Elementery/Secondary (0-12) C	onede (1-4 ot 2 +)		EWIFE			AT H	OME	
S	17. FATNER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)		
BE	OSCAR-EDUAR					EUGENIA		RANZ	EVA
2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
	MICHAEL JAKOBSON SAME AS ITEM #10 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City of Town, State							70.	
	1 Burial 2A Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cemetery, cre.	metory or othe	CREMA	ጥORV	1 1 1	IVER		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	EE /	24,0		ND ADDRESS OF FA	CHITY			
	MO0091 W. W. CHAMBERS CO. INC. 2						20910		
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart feliure. List only one cause on each line. Approximate interval Bett Onset and Con							Approximate interval Between Onset and Death	
	resulting in death) a	resulting in death) a. CEREBRA hemmorhage DUE TO (OR AS A CONSEQUENCE OF): 48 Los							
ATION	Sequentially list conditions. CateRiosche 2011								
	oue to (DR As A CONSEDUENCE OF): (If any, leading to immediate cause. Enter UNDERLYING								
FIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFIC	resulting in death) LAST								
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
PHYSICIAN: MEDICAL		The second secon	souting in	the onderlyin	g couse given in	PERFOR	IMED?	AWA	ME AUTOPSY FINDINGS MALE PRIOR TO MPLETION OF CAUSE
9	1 TYES 2 NO						OF	DEATH?	
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							TES 2 NO	
CIA	25. WAS CASE REFERREO TO MEDICAL 26. PLACE DF DEATN (Check only one)								
YSI	t VES 2 NO 1 Nopatlant 2 ER/Outpatlant 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)								
	27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME DF INJURY WORK?				28d. DESCRIBE HOW INJURY OCCURED			
BY	2 Accident Investigation 3 Suicide 2 Could get by 28e. PLACE DF INJURY — At home, term, street, tactory, office					281. LOCATIDN (Street and Number or Rural Route Number,			
ij	Suicide					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED	29a. CERTIFIER (Check only (Ch								
NO.	one) 2 MEDICAL EXAMINER: Dn the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner es stated.								
ш II	29b. SIGNATURE AND TITLE OF DENTIFIER	0			29c, LICENSE NUI	IBER	29d. DATE S	SIGNED (Mo	nth, Day, Year)
TO B	Elect Janon wo 103429 > 3/22/62.							195	

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

118

DHMH-16 Rev 1/89

J -

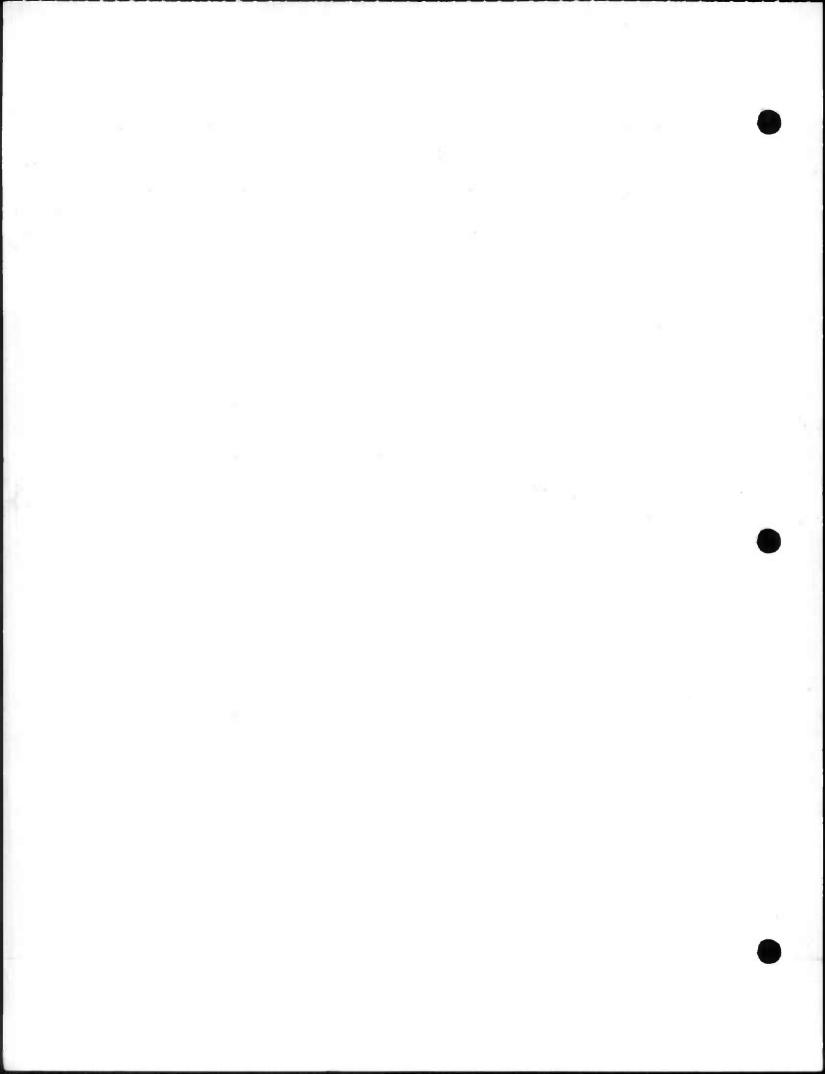
TO BE COMPLETED BY FUNERAL DIRECTOR

		1 1 2 1	11 1 - 1 - 0	1111111111
TATE	OF MARYLAND	/ DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
		CERTIFICATE		REG. NO.

STATE REGISTRAR		STATE 0	F MARYL					HEALTH F DEAT		MENT	AL HYGIENI REG. NO.			f
1. DECEDENT'S NAME (First	, Middle, La	ist)				- I		DEAL		2 DA	TE OF DEATH			3. TIME OF DEATH
OUISE ADAMS	1	1	Duis	0	41	2 00	-			FF R	RUARY 2	່າ 1	Q Q S	5:29A M
4. SOCIAL SECURITY NUME		5. SEX	-	(In yrs. last		IF UND	ER 1 YEAR	IF UNDER	24 HRS	_	TE OF BIRTH	J, I		PLACE (State or Foreign
218-56-6229)	1 🗆 M 2 🛛		44	YRS.	MONTHS	-	-	MIN.	(Mo	onth, Day, Year)	5.1	Countr	y)
9e. FACILITY NAME (If not in	stitution, air	ve street and number	}			9h, CI	TY TOWN	OR LOCATION	ON OF DE		b. 1,19		NTY OF O	nington, DC
		HOPKINS		TAT		55. 01.								EAIN
RESIDENCE OF DEC			110311	IAL			DAL	TIMOR	E CT	II		N	one	
10e. STATE	10b. COU	INTY			10c. CIT	Y, TOWN	OR LOC	ATION						10d. INSIDE CITY
Maryland		Montgome	ery	- 1			Roc	kville	9					LIMITS?
10e. STREET AND NUMBER							1	IOI. ZIP CODE	Ē			10g. CIT	IZEN OF W	HAT COUNTRY?
13211 Keatin	ng St	reet						208	353			Un	ited	States
11. MARITAL STATUS		12. WAS DECE				13	3. WAS OF	ECENDENT O	F HISPAN	IIC ORIG	GIN? (Specify Yes		14. RACE	— American Indian,
1 Never Married 2			1 NES)		If yes, a		n, Maxica	n, Pueri	o Rican, atc.)		Black Specif	, White, etc.
3 Widowed 4 X Divo	orced							32,	opcomy				Gpaci.	"White
	EDENT'S E	EDUCATION rade completed)		16a. DECI	EDENT'S	USUAL	OCCUPAT	TION most of workin		1	6b. KIND OF BUS	INESS/IN	DUSTRY	
Elementary/Secondary (0		College (1-4 c	or 5 +)	life. L	Do NOT us	e retired.	(.)	nost or working	v					
12		_		Bo	okke	eepe	er				Physic	ian'	s Off	fice
17. FATHER'S NAME (First, M	liddle, Last)							18. MOTH	IER'S NA	ME (Firs	t, Middle, Malden S	Sumame)		
John d	J. Ma	ckey						I	Bert.	ha :	Fowler			
19a. INFORMANT'S NAME (7	Type/Print)			19b.	MAILING	ADDRE	SS (Street	and Number	or Rural F	Poute Nu	ımber, City or Town	State, Zij	o Code)	
Bertha F. I:	sbell	_		13	3211	Kea	atino	g Stre	eet,	Ro	ckville	, Ma	rylar	nd 20853
20a. METHOD OF DISPOSIT	ION		200	D. PLACE AN	ND DATE (OF DISPO	OSITION (Name of 2 / 2	24/9	5 0	ATE 20c. LOC	ATION -	City or To	wn, State
1 Donetion 5 Other		emoval from State	cer	netery, crem	afory or ol	her place	6)				Betl	nesd	a. Ma	arvland
21. SIGNATURE OF FUNERA	L SERVICE	LICENSEE	,	011090	Ziii C I	22	2. NAME	AND ADDRES	S OF FA	CILITY	Robert A	A. P	umphi	rey Funeral
Mil	4	04	-			1 1	KOCK'	ville	, in	C.,	300 W.	Mon	tgome	ery Ave. Home
Much	le	G. 77	ua)		348					_	and 208			
23. PART I. Enter the d	iseeses, d eert fellui	or complications re. List only one	thet ceuse	d the deer	th. Do n	ot ente	er the m	ode ot dyi	ng, suci	h as ce	erdisc or respir	atory ar	rest,	Approximate
IMMEDIATE CAUSE (FIR		00 00 00 00												Onset and Death
disease or condition	\rightarrow	s. Ru	sture	Cer	ebr	al	An	eurys	m					06 2000
The state of the s		DU	TO (OR AS	A CONSEQU	JENCE OF	7:		9						1 0 o drags
		- b ++v	perte	nsin	2									Olyear
Sequentially list conditi if any, leading to imme-		οὐί	TO (OR AS	A CONSEQU	JENCE OF	7:								
cause. Enter UNDERLY!		a Mo	rbid	05	12 517	4								20 years
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resulting in desth) LAS	' (d												
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DID TOBACCO U			CAUSE C			_			ERTAIN	1 🔼				
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27. MANNER OF OEATH			th, Day, Year)		26b. TIMI	E OF URY	28c. IN	JURY AT		28d. O	EŞCRIBE HOW IN	JURY OC	CURED	
	Pending Investigation					М		YES 2	NO					
3 Sulaide	Could not I	28e. PLAC	E OF INJURY	At home	e, farm, s	traet, fa	ctory, off	Ica		281. LC	OCATION (Street ar	d Number	or Rural A	oute Number,
4 Homicide	determined		my area (open	uny)						G	ty or Town, State)			
290. CERTIFIER 1 X CERT	IFYING PH	YSICIAN: To the bea	at of my know	dech enhel	h occurre	d at the	time de	to and place	and due	to the o	20100(0) 2010			
														end manner as stated.
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29b. SIGNATURE AND TITLE	OF CERTIF	Dur	LI A	ne sthas	16/034	Res	ndert	29c. LICE	STO	BER) W		29d. DAT	E SIGNED	(Month, Day, Year)
30. NAME AND ADDRESS OF	PERSON	WHO COMPLETED					-	HUY	TINH	1 .				
600 NORTH	WOI	FE STRI	EET/	BA	LTI	U OP	- 1	nD 2	128	7	- 4963			
31. DATE FILED (Month, Day,			TRAR'S SIGN							1				
FEB 281	1995	Jalia da	volson	ardall										
1 2 0														

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

by the hospital or attending physician.	be detached for use as the bunal-transit permit. Pages 1.2.3 should		at once.
TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLAN		TMENT OF H		MENTAL HYGIENI REG. NO.	Ε	
	1. DECEDENT'S NAME (First, Middle, Last)					2. OATE OF DEATH		3. TIME OF DEATH
	VIRGINIA	BRUMBAU	IGH			FEBRUARY :		5 2:30 A M
	4. SOCIAL SECURITY NUMBER 5. S		rs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	8. BIR	THPLACE (State or Foreign ntry)
	-30 07 77 10K		89 YRS.			05/23/7905	P	Α
œ	90. FACILITY NAME (If not institution, give street of Homewood Nursing Center	nd number)		Williamsp	ort. MD	EATH	9c. COUNTY OF	
57.	RESIDENCE OF DECEDENT			т.			wasni	ngton
DIRECTOR	10e. STATE 10b. COUNTY		100	, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
	MD Washingt	on	Wi	lliamsport				1 YES 2 NO
FUNERAL	16505 Virginia Ave.			101	21795		10g. CITIZEN OF	WNAT COUNTRY?
UNE	11. MARITAL STATUS 12. 1	WAS DECEDENT EVER IN U.	S. ARMED	13, WAS DEC		IIC ORIGIN? (Specify Yes	or No.— 14. RA	CE American Indian,
BY F		FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATE		If yes, sp		n, Puerto Rican, etc.)	Bla	ck, White, etc.
		- T-						White
COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade complete)	leted)	(Give kind of w life. Do NOT us	USUAL OCCUPATION From done during mo From retired.)	ON st of working	16b. KIND OF BUS	INESS/INDUSTRY	
PLE	Elementery/Secondery (0-12) Cot	flege (1-4 or 5 +)	Nurse	,		Medica	2]	
Ö	17. FATHER'S NAME (First, Middle, Last)		1141 30		16. MOTHER'S NAI	ME (First, Middle, Maiden S		
BE (Edward C. Brumbaugh				Rhoda S			
6	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Town		
	Christina B. Ellis				Hagersto			
	20a, METHOD OF DISPOSITION t		ry, crematory or of	her place)		DATE 20c. LOC	· ·	
	21. SIGNATURE OF FUNERAL SERVICE LICENSE		uar niii	Cemetery 22. NAME AN	D ADDRESS OF FAC	13/3/95 Gree	<u>encastle,</u> Millor Mo	y Funeral Home
	redbuttt ha			521 S.	. Washingto	on St. Green	castle. P	A 17225
	23. PART I. Enter the diseases, or compl	fications that caused th	ert C. Ma					Approximate
	ahock, or heert failure. List o	only one cause on each	line.					Interval Between Onset and Death
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Ĕ	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A CO	INSEQUENCE OF):				
CERTIFICATION	resulting in deeth) LAST							
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Ä		28e. DATE OF INJURY	26b, TIME	OF 28c. INJ		26d. DESCRIBE HOW IN	JURY OCCURED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	ІІЛІ		PK? ES 2 NO			
ED B	3 Suicide 6 Could not be	28e. PLACE OF INJURY — ibuliding, etc. (Specify)	At home, ferm, a	treat, fectory, office	,	26f. LOCATION (Street ar City or Town, State)	nd Number or Rura	Route Number,
	4 Homicide determined							
COMPLET		To the best of my knowledg						
8	2 MEDICAL EXAMINER: On	the beste of examination en	d/or Investigation	n, in my opinion, d	eath occured at the	time, date end place, end	due to the cause	(e) end manner es stated.
BE	29h, SIGNATURE AND TITLE OF CERTIFIER		1 1		290 LICENSE NUM	BER ?	29d. DATE SIGNE	O (Month, Day, Year)
2	NAME AND ADDRESS OF PERSON WHO COM	IPLETED CAUSE OF DEATH	(ITEM 27) (Type,	Print)	.7 -30		- 410	0(7)
	Frederic It. K	ASS 111 V	1 000	7994	towell.	Red Here	ers town	a had
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATU	RE	*	1			
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR	c event, the medical examiner must be notified at once.	rial, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	uted within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	IMPURIANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

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2 Accident 3 Suicide 4 Homicide 5 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceust of the country of the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceust of the country opinion, death occurred at the time, date end place, and due to the ceust opinion of the country opinion opinio	JUNED	OESCHIBE HOW INJURY OCCURED	DRK?	Y W		(Month, Day, Year)								
3 Suicide 4 Homicide 5 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner se stated. 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause (e) and manner se stated. 29e. LICENSE NUMBER 29e. LICENSE NUMBER 29d. DATE SIGN			YES 2 NO	M 1					≿					
29c. LICENSE NUMBER 29d. DATE SIGN Feb. 3	or Rural Route Number,	OCATION (Street and Number or Rura		et, factory, off	At home, ferm, stre	28e. PLACE OF INJURY	6 Could not be	3 Suicide 6						
29c. LICENSE NUMBER 29d. DATE SIGN Feb. 3		Ally or lown, State)			777		determined	4 Homicide						
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29c. LICENSE NUMBER 29d. DATE SIGN Feb. 3								(Check only	<u>a</u>					
29c. LICENSE NUMBER 29d. DATE SIGN Feb. 3	e ceuse(a) and manner ee stated.	late end place, and due to the ceuse	lesth occured at the time,	In my opinion,	end/or investigation,	R: On the beele of examination	MEDICAL EXAMINE	2 ME	6					
Dog 93/0 Feb. 2														
1/0074/0 1 Feb. 2	E SIGNED (Month, Day, Year)					2.15%	1111/	1111	BE					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)	b.23,1995	€ Feb.2	10093			MMM	11/1							
				int)	TH (ITEM 27) (Type, Pri	COMPLETED CAUSE OF OR	SS OF PERSON WH	30. NAME AND ADDRESS	-					
May F Byrkit MD 28 W Potomac St. Williamsport MD 21705			+ MD 21705	amcro=	S+ MILLE	8 W Potomos	-ki+ MD 2	May F Runk						
Max E.Byrkit, MD 28 W.Potomac St. Williamsport, MD 21795 31_DAIE_FILEO (Montr, Day, Year) / 32. REGISTRAR'S SIGNATURE			1 JUN 21790	ашѕрог	THOS	22 DECICEDADIO CICA	Day Year)	31_DATE FILED (Month De	Jł.					
31_DATE FILEO (Month, pay, Year) Jalia Shurling Revolution					as a	Aburt P	995 61	FFB 2 3 190						
					4	- market store	July July	20 10.						

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) Myrtle Blanche BOWMAN 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 X F 213-16-9277 84 permit, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Garrett County Memorial Hospital Oakland 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Garrett 0akland 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal. 23 North Fourth Street 21550 retained by the hospital or attending physician, 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Married 2 Married BY 3 🔀 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) ost of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Housewife 17. FATHER'S NAME (First, Middle, Last) 끃 Bert ----Paugh Mae BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 23 N. Fourth St., Oakland, MD 21550 Margaret Morgan hours after death. Page 6 may be pe 20s. METHOD OF DISPOSITION
1 Like Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) DATE 20b. PLACE AND DATE OF DISPOSITION (Name of must netery, cramatory or other place)
Oakland Cemetery 2/24 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home

32 S. Second St., Oakland, MI

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. 32 S. Second St., Oakland, MD medical IMMEDIATE CAUSE (Final event, the disesse pr condition Heart Furlure Congestine reaulting in death) executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL been signed by the any DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [] NO [3] PHYSICIAN: Dept. this certificate has the with the State Dept 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 KNO 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked. 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO DIRECTOR; After the hours after death vitem 28 is mart BY 28s. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29s. CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, dash occurred at the time, date and place, and due to the cause(s) end manner as stated. TO THE FUNERAL OF The FUNERAL DE FILE WITHIN 72 ho

29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

Smil

FEB 2 4 1995

Dr. P. Daniel Miller, DO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Navilson-Rank

2255 G.W. Plaza. Rt. 135E, Oakland, MD

BE

2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE BEG NO 2. DATE OF DEATH 3. TIME OF DEATH 1995 February 10:10 A 7. DATE OF BIRTH (Month, Day, Year) Apr. 23, 8. BIRTHPLACE (State or Foreign 1910 Maryland 9c. COUNTY OF DEATH Garrett 10d. INSIDE CITY 1 K YES 2 NO 10g, CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify. White 16b. KIND OF BUSINESS/INDUSTRY Home 18. MOTHER'S NAME (First, Middle, Malden Surname) Collins. 20c. LOCATION — City or Town, State Oakland, MD 21550 Approximate interval Between Onset and Death Days 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 1 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2 MEDICAL EXAMINER: On the besid of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) end manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) H26154 2/22/95

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ex-nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If them 28 is marked, or them 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

	REGISTRAN				CERTIF	IUAII	_	DLA	111	RE	G. NO.	_		
	1. DECEDENT'S NAME (First, Mid									2. DATE OF D	EATH DAY		YEAR	3. TIME OF DEATH
		uline	Bar	ker						Februa:	ry 26	5, 19	995	9:00 p M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last in					IF UNDER		IF UNDER		7. DATE OF 81 (Month, Day,	RTN			PLACE (State or Foreign
	None		1 ☐ M 2 💢 F	96	YRS.	MONTHS	DAYS	HOURS	Miles.			899	West	Virginia
	9a. FACILITY NAME (If not institut	tion, give str	eet and number)			9b. CITY	, TOWN	OR LOCATION	ON OF O		-	9c. COUN		
E I	Garrett Coun	tv Me	morial F	losnit:	a 1		0	aklaı	nd			Ga	rret	+
18	RESIDENCE OF DECED	DENT	morrar i	roopiet				an zu			_			
DIRECTOR	10a. STATE 10i	b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
	MD	Garr	ett			Mt.	Lak	e Pa:	rk					1 X YES 2 NO
A	10a. STREET AND NUMBER						10	. ZIP CODI	E			10g. CITIZ	EN OF W	HAT COUNTRY?
FUNERAL	700 Deer Parl	k Ave						2	1550			II	SA	
	11. MARITAL STATUS		12. WAS OECEOEN	T EVER IN U.S	. ARMED	13.	WAS DEC			VIC ORIGIN? (Sp	ecify Yes o			- American Indian.
	1 Never Married 2 Mar		FORCES? 1 IF YES, GIVE W				If yes, sp	ecify Cuba 2 📝 NO	n, Mexica	n, Puerto Rican,	etc.)		Black	, White, etc.
BY	3 🕅 Widowed 4 🗌 Divorced	4	ii reo, dive v	AN ON ONIES			1 1 163	2 DE NO	Specin	y:			Specif	White
COMPLETED	15. DECEDE			16a	. DECEOENT'S	USUAL O	CCUPATIO	ON		16b. KIND	OF BUSIN	NESS/INDI	USTRY	
ᇤ	(Specify only hig Elementery/Secondary (0-12)		College (1-4 or 5 +	<u>, </u>	(Give kind of life. Do NOT u	work done se retired.)	during mo	st of workir	ng					
립			2+	´	Schoo	l Tea	ache	r		Ele	ement	ary	Educ	ation
8	17. FATNER'S NAME (First, Middle	s, Lest)	-						NER'S NA	ME (First, Middle,		_		
E C	Franklin	В.	Cathe	er						aret				Love
🕮	19a. INFORMANT'S NAME (Type/		000		19b. MAILING	AOORES	S (Street a	1		Route Number, Cit	ty or Town	State 7in	Codel	
임	Patricia Whi	te								Mt. Lak				21550
	20a. METNOD OF DISPOSITION			20h BI 4	CE AND DATE						20c. LOCA			
	1 Buriel 2 Cremation :	3 🗌 Remo	val from State	cemeter	cremetory or o	ther place!				1				7.5570
	21. SIGNATURE OF FUNERAL SE		NSEF 1	- В.	Luemon			TY ND ADORE		3/1	Gr	afto	n, w	/ V
	0 M	N TH	h. 1			1 "				eral Ho	ome			
	Stelle	1-3	(DWKL)			3:				St., 0a		d, M	D 2	21550
	23. PART I. Enter the disea	ses, or co	omplications that	t caused the	deeth. Do	not enter	the mo	de of dy	Ing, suc	h aa cardiac d	or reapire	tory arre	ent,	Approximate
	shock, or heart fellure. Liet only one ceuse on each line. Interval Between Onset and Death													
1 1	disease or condition													
1	a. Ventricular Arrhythmia, Acute Sudden Sudden													
,	Amtoniogalaused C. 11 VI . 1													
CERTIFICATION	Sequentielly list conditione, ff any, leading to immediate But TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):									Unknown				
¥	cause. Enter UNDERLYING													
표	CAUSE (Disease or injury that initiated evente) "	DUE TO	(OR AS A CO	SEQUENCE O	F):								
분	resulting in deeth) LAST													
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EDICAL	PART II. Other eignificent of										WAS AN AL		24b.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
18	Amputation	n of	right le	g 2/23	3/95-	Mult:	iple	ulce	ers		YES 2			COMPLETION OF CAUSE OF DEATH?
1 = 1	Amputation										X.			1 YES 2 NO
2	DID TOBACCO	USE C	CONTRIBUT	E TO C	AUSE O	F DEA	TH	YES [N	C C				
₹	25. WAS CASE REFERRED TO ME									eck only one)				
PHYSICIAN:	EXAMINER? XX YES 2 \(\square\) NO		HOSPITAL:	ER/Outpatien	t 3 🗆 DOA	OTHE	R:				no#64			
Ě	27. MANNER OF DEATH		28e. OATE OF	INJURY	28b. TIN	-	28c. INJ		rardence	8 Other (Spe 28d, DESCRIB		URY OCC	URED	
	1 Natural 5 Pend		(Month, D.	ay, Year)	IN.	JURY M	WC	RK?	NO.					
A	a Culsta	atigation	28e. PLACE O	F INJURY — A	t home, ferm.	atreet fec				281. LOCATION	(Street en	d Mumber	or Russi D	Inute Mumber
		ild not be ermined	bullding,	etc. (Specify)			ory, onto			City or Tow		a reamper i	or rigral ri	odie Number,
MPLET	29a. CERTIFIER													
릴	(Check only	only 1 GERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated.												
one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(a) end) end manner as stated.						
ш	296. SIGNATURE AND TITLE OF	CERTIFIER	10	. /	/	1 _		29c. LICI	ENSE NUI	WBER	:	29d. DATE	SIGNED	(Month, Day, Year)
100	Hirbert	14	100	5 hl	on, 1	he. I	1	ת	056	58		▶ Fe	brua	ry 26, 1995
임	30. NAME AND ADDRESS OF PE	RSON WHO	COMPLETED CANS	SE OF DEATN	(ITEM 27) (Type	, Print)		D	0.70	70				,,,
	Herbert H. I						ree	- 0-	110	ad Mass	171	a 2	1550	
	31. DATE FILED (Month, Day, Year		62. REGISTRA	R'S SIGNATUR	3E	*K 01	166	, Ua	rvrql	iu, Har	Aran	u 2	TOOU	
_ 8	FEB 2 8 19	395	This offer	dear Ray	dall									I
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s after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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burial-transit

completely filled in by the funeral director, page 5 should be detached for use as the rial, cremation, or removal.

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the attending phy.

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After death

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31. DATE FILED (Month, Day, Year)

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32. REGISTRARS SIGNATURE

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	THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	p
	F	Ŧ	File

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JOEL. YEAR OLIVER BAZZELL Feb. 25 1995 12:55 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Yo. Oct. 8, MONTHS 217-16-4012 1 X M 2 - F DAYS HOURS 71 YRS. 1923 Maryland 9e. FACILITY NAME (If not institution, give street end number 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 27078 Deer Dale Road Princess Anne Somerset RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Somerset Princess Anne 1 YES 2 XNO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 27078 Deer Dale Road 21853 U.S 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced Specify WWII White 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Distributor Hydrazo Ink once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme notified at Joel Bazzell BE Beulah Reedy 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy Bazzell 27078 Deer Dale Road. Princess Anne. pe Md. 20e. METHOD OF DISPOSITION

1 M Burlel 2 Cremation 3 Removal from State must 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) Oriole Cemetery 2/28 Oriole. Md examiner 21. SIGNITURE OF FUNERAL BETYICK LICENSEE 22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home human M00295 or removal. Princess Anne. Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, auch as cardiac or respiratory arrest, Approximate ahock, or haart failure. List only one cause on each line. intarval Betwe IMMEDIATE CAUSE (Final Onset and Daath the disease or condition_ LUNG CHRCINOMA METASTATIC
DUE TO (OR AS A CONSEQUENCE OF): event, reaulting in death) mth traumatic CERTIFICATION Sequantially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): or other OUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST shows any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER: Inpatient 2 - ER/Outpetient 3 - DOA ne 5 Rasidenca 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED Natural . 5 Pending Investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town: State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 GERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) D36576 27 2 O ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Russisle DR Salislay MD 21801

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL

30. NAME

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OF ALL ENDING PRISIDIAN: THE LAW INQUIRES THAT THE DESTRICTED BE EXECUTED WITHIN 24 HOURS SHEET DESTRUCT BY THE HOSPITAL OF STRENGING PHYSICIAN.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages		andiffed of once
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 CLARENCE JR. FEB. WILLIAM BRADLEY 10 1:24 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year)
JUNE 13,1918 DAYS HOURS 222-10-5570 1 X M 2 - F 76 YRS. MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH DIRECTOR DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND DORCHESTER EAST NEW MARKET 1 📉 YES 2 🗌 NO FUNERAL 10e, STREET AND NUMBER 101, ZIP COOF 10g, CITIZEN OF WHAT COUNTRY? MAIN STREET 21631 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ВУ Specify: 3 Widowed 4 Divorced WWII WHITE COMPLETED 15. OECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) HOUSE PAINTER-SELF EMPLOYED 8 PAINTER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIAM CLARENCE BRADLEY, SR. LENA SAUNDERS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 C. SYDNEY BRADLEY P. O. BOX 188, EAST NEW MARKET, MD 21631 20a. METHOO OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 N Buriel 2 Cremetion 3 | | 4 | Donation 5 | Other | Specify) EAST NEW MARKET CEMETERY 2/13 EAST NEW MARKET, MD 21. SIGNATURE OF FIRMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631 23-PART LEnter the disessea, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heert failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ ertiz C enosci reaulting in death) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART, if. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO some er COMPLETION OF CAUSE 1 TES 2 NO OF CEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 VES 2 NO Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28a. OATE OF INJURY (Month, Day, Year) 1 Statural 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 5 Pending M 1 YES 2 NO ВУ Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homleide detarmined COMPLET 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II (Check only MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) O.C.M.E. ▶ FEB.10,1995 2

WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

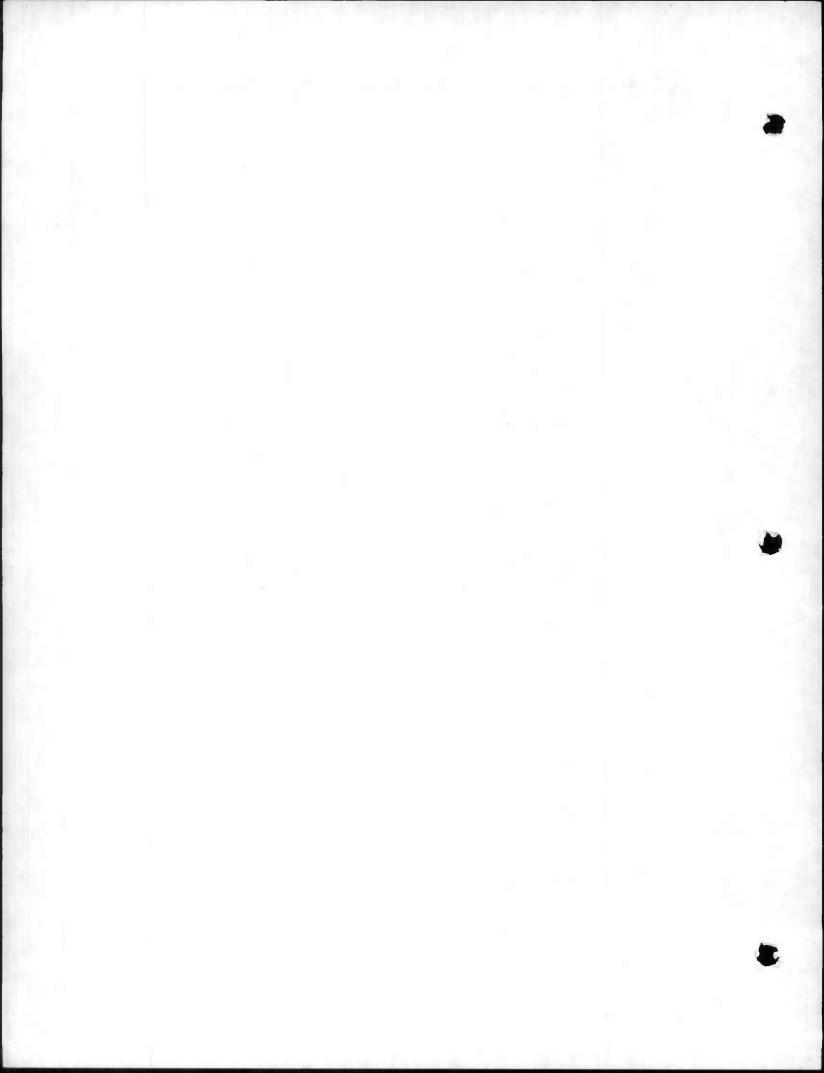
32. REGISTRAR'S SIGNATURE his Devoler Ravfall

111

Penn Street, Baltimore, Maryland 21201

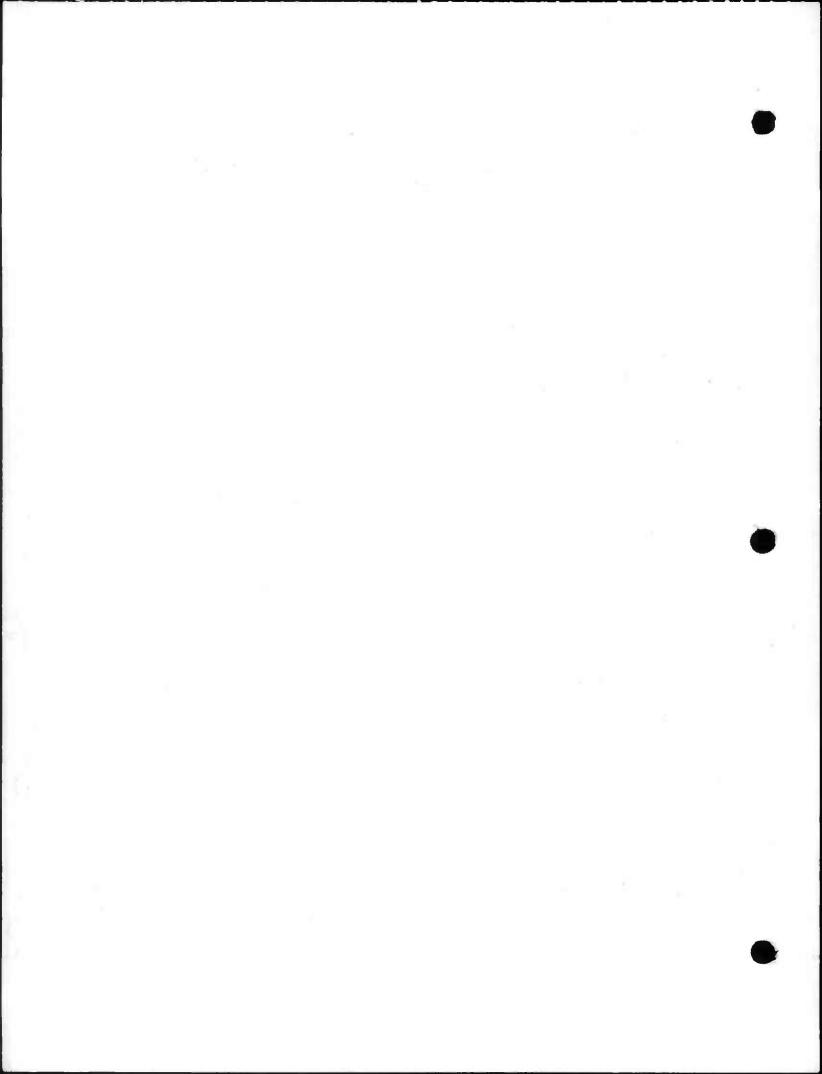
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	IENT OF HEALTH AN	D MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Las	10)			2. DATE OF DEATH		3. TIME OF DEATH				
	FANNIE R	OBERTS	Boz	man	February 23	1995 YEAR	2349 M				
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 H	RS. 7. DATE OF BIFTH	8. BIFTT	HPLACE (State or Foreign				
	214-74-6840	214-74-6840 1 M 2 XF 87 YRS. October 3, 1907 Mar									
]	99. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 9b. CITY, TOWN OR LOCATION OF DEATH WICOMICO WICOMICO										
9		VAL MEDICAL CEN	VIER	SALISBURY		WICON	ALCO				
[[RESIDENCE OF DECEDENT 10e. STATE 10b. COU	NTY	10c CITY T	OWN OR LOCATION			10d. INSIDE CITY				
DIRECTOR	Maryland Wi	comico		alisbury			LIMITS?				
	10e. STREET AND NUMBER	e omize o		101. ZIP CODE		10g. CITIZEN OF					
ER/	418 E. Vine St	•		2180	1	US					
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	U.S. ARMED		SPANIC ORIGIN? (Specify Ye	s or No 14. RAC	E — American Indian,				
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, specify Cuben, Me 1 TES 2 TNO S	oxican, Puerto Rican, atc.)	Spec	k, White, etc.				
						Whi					
	15. DECEDENT'S EI (Specify only highest gra	JUCATION ide completed)	(Give kind of work	JAL OCCUPATION done during most of working tired.)	16b. KIND OF BU	SINESS/INDUSTRY					
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homemake								
once.	17. FATHER'S NAME (First, Middle, Last)		Homemake		NAME (First, Middle, Maiden	01					
# O	George W.	Roberts		Daisy		Mills					
fled a	19e. INFORMANT'S NAME (Type/Print)		19b. MAJLING AD	DRESS (Street and Number or A	ural Route Number, City or Tow	yn, State, Zip Code)					
1 1	Shirley Bozman	l		Vine St., S							
examiner must be notified at once. TO BE COM	20s, METHOD OF DISPOSITION 1 □XBuriel 2 □ Cremetion 3 □ Re		PLACE AND DATE OF D		DATE 20c. LC	CATION — City or To	own, State				
Ë	4 Donation 5 Other (Specify)	Pa	ery, cremetory or other rsons Cen	netery	2/27 Sal	lisbury,	MD				
i i	21. SIGNATURE OF FUHERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home										
exa	501 Snow Hill Rd., Salisbury, MD 21801										
medical	23. PART i. Enter the diseases, p	r complications that caused	he deeth. Do not	enter the mode of dying,	such as cerdiac or reap	iretory srrest.	Approximate				
	snock, or heart failure. List only one ceuse on each line. Interval E IMMEDIATE CAUSE (Fine)										
=											
event,	disease or condition resulting in death) a. ARDAC APPREST DUE TO (OM AS A CONSEQUENCE OF): Sequentially list conditions. b. Almosclustic Cardiovascular disease										
	Conventially, list one divines	Arterose	lentic	Cardeovo	scular de	elast					
injury, or other traumatic	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF):								
ry, or other traumatic	CAUSE (Disesse or injury	cDUE TO (OR AS A C	ONOFOLIENOE OF								
	that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A C	ONSEGUENCE OF):				1				
CE 12		, d					İ				
	PART II. Other eignificant condition	ons contributing to death but			A PERFOR		WERE AUTOPSY FINDINGS				
E S	Ventricus	las Vachy	ardia	suo Taine	el 1 □ YES 2		COMPLETION DF CAUSE OF DEATH?				
shows any							1 TYES NO				
red, or item 23 shows any PHYSICIAN: MEDIC	DID TOBACCO USE CON				AIN 🗆						
E C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	S. PLACE OF DEATH (Check only one)							
S	1 TYES 2 NO	1 Department 2 ER/Outpati	lent 3 DOA 4	Nursing Home 5 Raelder	ce 8 Other (Specify)						
	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WORK?	28d. DEŞCRIBE HOW I	NJURY OCCURED					
	2 Accident Investigation	28e. PLACE OF INJURY —	At home form stood	M 1 YES 2 NO							
TED TED	3 Suicide 8 Could not b 4 Homicide datermined	building, atc. (Specify,)	t, lectory, binca	281. LOCATION (Street : City or Town, State)	and Number of Hural I	Houte Number,				
	29a. CERTIFIER										
M M		SICIAN: To the best of my knowled									
8											
BE COMPLE	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mogth,										
일	30. NAME AND ADDRESS OF PERSON V	WHO COMPLETED CAUSE OF DEAT	H (ITEM 27) /Tuna Dela	V 303		1/07	190				
	KENE DESMAKA	IS SION RIVI	9/3/04 1	1. BIOI	5 ALISBUM,	Mo el	101				
	31. DATE FILED FEB 2 7 199	32 ARGISTRAR'S SIGNATI	URED	15/01							
	FEB 27 199	5 July Dander	Nordall								



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

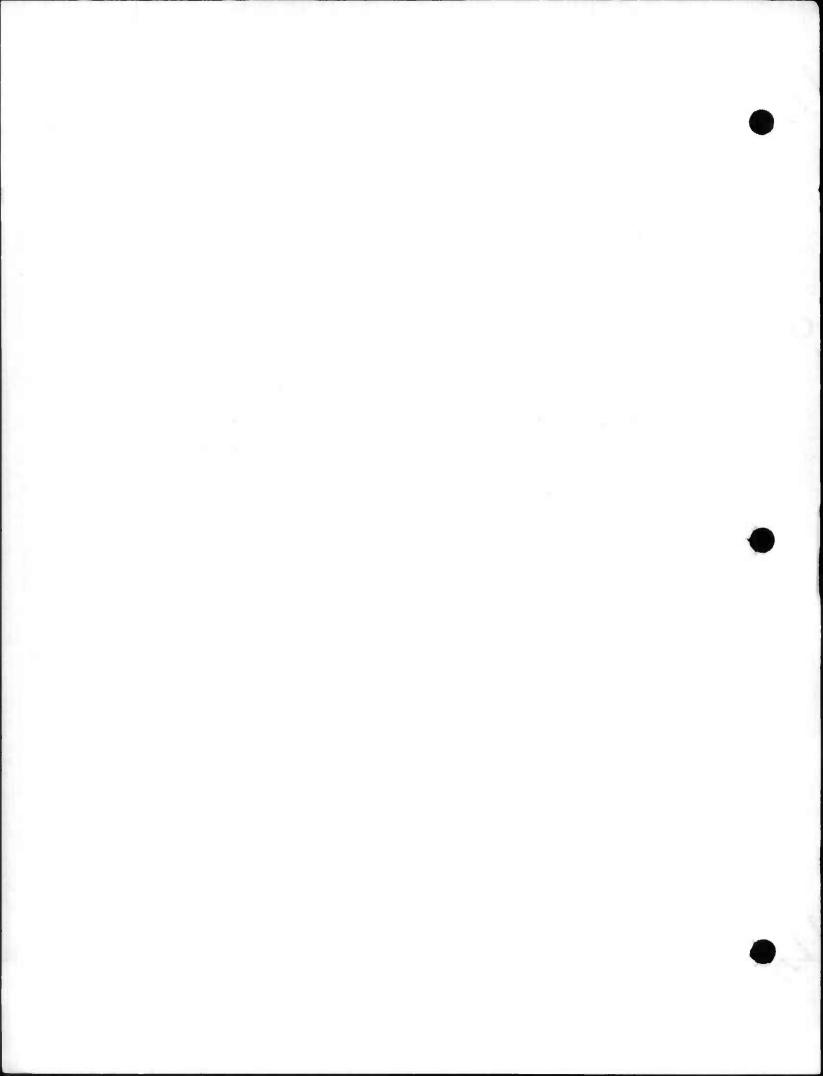
IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

_	REGISTRAR	CEF	RIFIC	ALE OF	DEATH	RE	G. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH		3. TIME OF D	EATH		
	MALCOHM SIDNEY	BUNDIC	K			FEB.	18, N 1995	YEAR	12:40	PM M		
		. AGE (In yrs. last bi	rthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BE	RTH		LACE (State o			
	227-03-7458 1 X M 2 F F	85	YRS.	THS DAYS	HOURS MIN.		4, 1909	VIRG	INIA			
OR	7440 CEMETERY AVENUE		96. CITY, TOWN OR LOCATION OF DEATH PITTSVILLE WICOMICO									
DIRECTOR	RESIDENCE OF DECEDENT			11011	0.0.12		MIOC	111.00				
믦	10s. STATE 10b. COUNTY	1	Oc. CITY, TO	WN OR LOCA	TION				10d. INSIDE C	YTE		
	MARYLAND WICOMICO		PITTS	VILLE					1 YES 2	NO NO		
FUNERAL	100. STREET AND NUMBER 7434 CEMETERY AVENUE				21850			IZEN OF WI	HAT COUNTRY	n		
S	11. MARITAL STATUS 12. WAS DECEDENT I		D	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Sp.	ecify Yes or No-		— American I	ndlan.		
ВУ Е	1 Never Married 2 Merried FORCES? 1 IF YES, GIVE WAF	YES 2 NO			S 2 X NO Specific		etc.)	Black, Specify	White, etc.			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give I	kind of work	AL OCCUPAT		16b. KIND	OF BUSINESS/IN	DUSTRY	WILLE			
9	Elementary/Secondery (0-12) College (1-4 or 5+)	life. Do	NOT use ret	ired.)	osi or working					_		
M P	10	MACH	INIST			FUEL	HANDLIN	ig Eqi	UIPMEN	T		
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle,	Maiden Surname)					
BE	GEORGE BUNDICK				LULA 1							
2	19a, INFORMANT'S NAME (Type/Print)				and Number or Rural				0			
-	MALCOHM P. BUNDICK	P.0	. BOX	192	PITTSVI	LLE, MA	RYLAND	2185	0			
	20a. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cametery, cremate PITTS	DATE OF D	SPOSITION (A place) CEME	TERY	2/21/9	5 PITTS		n, State E, MAR	YLAND		
	21. SIGNATURE OF ENNERAL SERVICE LICENSEE			22. NAME A	ND ADDRESS OF FA	CILITY						
	Kales W Acc	1			NGS FUNE				E, DE.	19975		
	23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximation of dying, such as cerdiac or respiratory arrest, interval E											
	IMMEDIATE CAUSE (Final											
	disease pr condition resulting in dasth) a. U~G CZ~CC DUE TO (OF AS A CONSEQUENCE OF):											
	DUE TO (O	AS A CONSEQUE	NCE OF):						1			
Z	Sequentially list conditions,											
CERTIFICATION	If any, leading to immediate	R AS A CONSEQUE	NCE OF):									
0	cause. Enter UNDERLYING CAUSE (Disease or Injury											
	that initiated eventa resulting in deeth) LAST	R AS A CONSEQUE	NCE OF):						1			
H	d											
	PART ii. Other eignificant conditions contributing to de	eath but not resu	alting in th	e underlylr	g ceuse given in	Pert I. 24a.	WAS AN AUTOPSY	24b.	WERE AUTOPS	Y FINDINGS		
EDICAL							PERFORMED?	- 1 -	AVAILABLE PRICOMPLETION C	OR TO		
E						'	YES 2 THO		OF DEATH?	10000		
Σ	DID TOBACCO USE CONTRIBUTE	TO CALISI	E OF I	SEATH	YES THE NO				1 NES 2	NO		
AN	25. WAS CASE REFERRED TO MEDICAL	10 0,000			LACE OF DEATH (Ch							
PHYSICIAN: M	EXAMINER? 1 ☐ YES 2 ☐ NO	D/Outpetlant 2 🗆	01	HER:						$\overline{}$		
Η̈́	27. MANNER OF DEATH 28e. DATE OF IN		8b. TIME OF		ne 5 Tesidence		E HOW INJURY OC	CUBED				
	1 Natural 5 Pending (Month, Day,	Year)	INJURY	W	YES 2 NO	ava. Degombi		DONED				
B	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF I	NJURY — A1 home,	farm, atree			281 LOCATION	(Street end Numbe	r or Aural Br	uta Numbar			
	4 Homicide determined building, at	c. (Specify)	,	.,,		City or Tow		or ridrai rio	ote rumber,	- 1		
۳	290. CERTIFIER			The Section			and the second					
P P	3 Suicide 4 Momicide 4 Momicide 5 Could not be datarmined 5 City or Town, State) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and due to the cause(e) and main and the time, date and place, and the time, date a											
	29b. SIGNATURE AND TITLE OF CERTIFIER											
BE	BA N-12				29c. LICENSE NUI	2 7	29d. DAT	E SIGNED	Month, Day, Ye	ar)		
၉	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH STEP OF	7 /Time Die	**	H 442	8 5	0	1/2/	171			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH (ITEM 2:	33	Heel	Thury	Duro	Ber	2.2	MD			
	31. DATE FILED (Month, Day, Year) FFR 2.2. 1995	S SIGNATURE	10			-						



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	OIME OF I	CE		CATE O			MENTAL	REG. NO				
1. DECEDENT'S NAME (First, Middle, Last)		-					2. DATE OF	F DEATH D	av	YEAR	3. TIME OF DEATH	
truestine		Bri	506	0			Feb	_ 2		95	2:55	PM
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	MONTHS DAY		24 HRS. MIN.	7. DATE OF (Month, L			8. BIRTH Countr	PLACE (State or Foreign)	gn
218-16-9036	1 🗌 M 2 🔀 F	70	YRS.	- DAT	HOURS	morre.	Jan.7	,1925	5	Mar	ÿland	
9e. FACILITY NAME (If not institution, give s				9b. CITY, TOW		ON OF OE	ATH		9c. COU	NTY OF D	EATH	
Joseph Richy Hosp	oice			Balt	imore					Bal	timore	
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CITY	TOWN OR LO	CATION						10d. INSIDE CITY	
Maryland Kent				stertov							LIMITS?	
10e. STREET AND NUMBER			0.10		10f, ZIP CODE				10a CIT	IZEN OF W	1 YES 2 X NO	_
10350 Fia	rlee Roa	d				2162	20		log. on	USA	MAI COOKTATT	
11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13, WAS D	ECENDENT O			Specify Yes	or No-		— American Indian,	-
1 Never Merried 2 X Married	FORCES? 1 IF YES, GIVE W	YES 2 N	10	If yee,	specify Cuber ES 2 X NO	n, Maxica	n, Puerto Ric			Specia	, White, etc.	- 1
3 Wildowed 4 Divorced					2,110	opeony				Speci	Black	
15. OECEDENT'S EDUC (Specify only highest grade	CATION completed)	/G/	ive kind of w	USUAL OCCUPA	TION most of workin	a	16b. K	INO OF BUS	SINESS/INC	DUSTRY		
Elamentary/Secondary (0-12)	College (1-4 or 5	r) life.	Do NOT use	retired.)	Thousand the state of							
12th		1 1	line I	Worker			Ca	mpbel	.1 So	up C	ompany	
17. FATHER'S NAME (First, Middle, Last)	76.7						ME (First, Mid		Sumame)			
Cleston W	IISOn						e War					
Diane Cunningham				AOORESS (Street								
200. METHOD OF DISPOSITION				Garland		τ, 1		7				
1X Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	cemetery crei	matory or oth	FDISPOSITION (Der piace) DUTCh ((Name of		Eebt C		CATION —		wn, State	
4 Donation 5 Other (Specify)	ENGEL _	I ASDU	iry Ci		AND ADORES		1400	Gec	rgeto	wn MD		_
			>					al Ho	me. (Chesi	tertown M	ın l
12/4									-			_
23. PART i. Enter the diseases, pro ahock, or heert fellure.	Omplications the	t caused the de	eth. Do no	ot enter the r	node of dyl	ng, eucl	h es cerdie	c or reepi	ratory arr	reet,	Approximete Interval Betw	
IMMEDIATE CAUSE (Finel											Onset and D	
disease or condition resulting in death)	a										Į	
W	DUE 10	ORAS A CONSEC	DUENCE OF):	1.		1					-1
Sequentielly list conditions,	a	OR AS A CONSEC	9/00	19 1	ANK	25					minute	5
if any, leading to immediate cause. Enter UNDERLYING	DOE 10	DH ISIN CONSEC	GENCE OF	1/10	ALC V	2	Zluis	_			1 /	- 1
CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEC	UENCE OF	LUI	77 4	10	2/11/) '			191	_
resulting in deeth) LAST	CA	710100		C	0/01	1.					Burs	- 1
	1										1-/-	
PART II. Other algnificent condition	s contributing to	deeth but not re	eeulting in	the underly	ing ceuse g	iven in	Part i. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDS	NGS
							1	YES 2	NO		COMPLETION OF CAUS	SE
							_				1 YES 2 NO	
DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DEA	TH YES	S NO	☐ UNC	ERTAIN	4 🗆 📗					_
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC		OTHER:	10)							
1 TYES 2 NO	1 Inpatient 2	ER/Outpatient 3	□ DOA	4 Nursing H	ome 5 🗆 Rec	sidence	8 🗹 Other (S	Specify)	Hos	7010	Ca	
27. MANNER OF DEATH 1 Naturel 5 Pending	28e. DATE OF (Month, De	INJURY ay, Year)	285. TIME INJU		NJURY AT WORK?		28d. DESCR	HBE HOW I	NJURY OC	URED		\Box
2 Accident Investigation					YES 2	NO						
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY — At hor etc. (Specify)	ne, farm, st	reet, tectory, of	fice		281. LOCATI City or	ON (Street a Town, State)	nd Number	or Rural R	oute Number,	
AND CENTREES												
29e. CERTIFIER (Check only one)												
2 MEDICAL EXAMINE	₹: On the beals of ex	cemination end/or is	nvestigation	, in my opinion	, death occure	ed at the	time, date en	d plece, en	d dua to th	e cause(e)	end menner ee state	d.
296. BIGNATURE AND TITLE OF CERTIFIER	12	1.)		29c. LICE	NSE NUM	BER		29d. DATI	E SIGNED	(Month, Day, Year)	
solles to	mi	WO)			100	890	10		12	.77.	95	_ 1
30. NAME AND ADDRESS OF PERSON WHE ROBOTY C.	- WWW	100	1 27) (Type, I	58 N	1.64	Yau	15X.1	Bark	(a.M	1/2	1201	
31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE	A 41					-100		6		
EED A 4 400E	and In	wellow have	Ka.Ili									

n signed by the a Health and Ment

has be Dept.

certificate h

this c marked,

After

DIRECTOR: Aft hours after de-item 28 is r

FUNERAL DIRECT WITHIN 72 HOURS A

TO THE HOSPITA
TO THE FUNERAL
Be filed within 72
IMPORTANT: II

HOSPITAL

PHYSICIAN:

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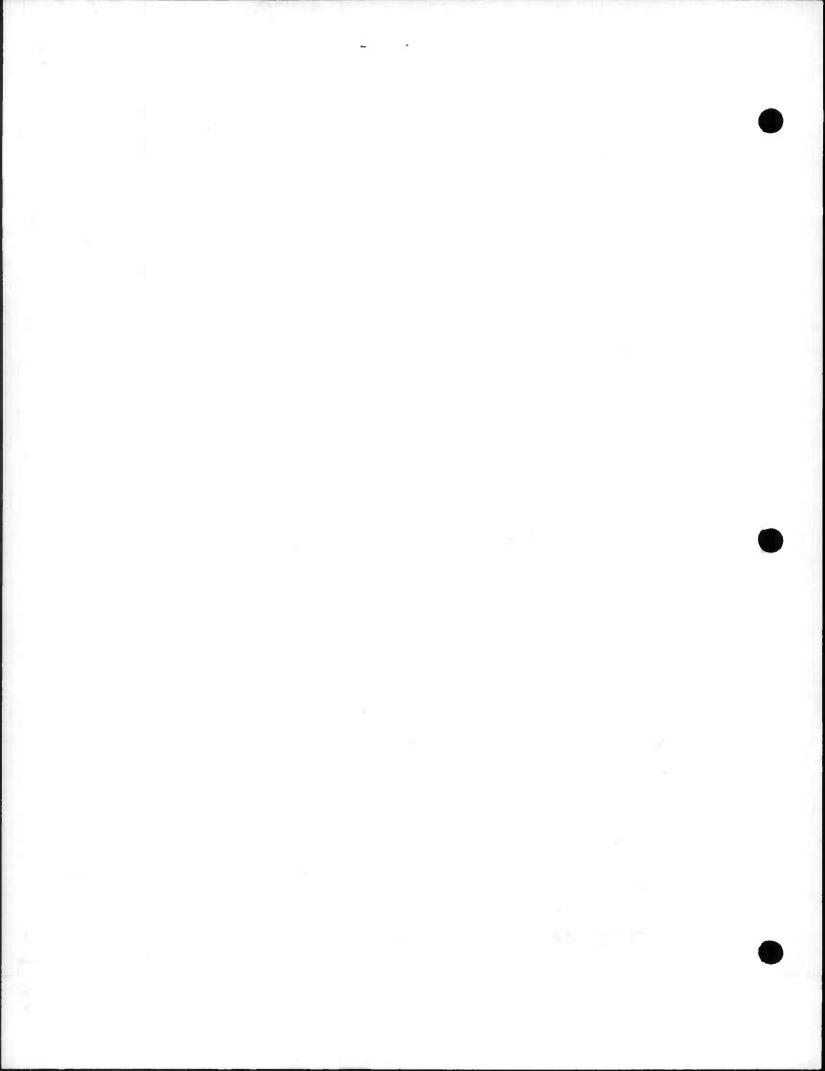
TO BE COMPLETED BY FUNERAL DIRECTOR	10e. \$ 1 1 1 1 1 1 1 1 1 1
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TO BE COMP	17. FA W] 19e. II 20e. II 1X II 4 1
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MEDICAL CERTIFICATION	Sequif an cause CAU that resu
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95 07729 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR VILLIAM HOWARD BLESSING Feb. 1995 5:46 CIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign HOURS DAYS 1X M 2 | F 6-40-3912 55 JAN. 4,1940 MARYLAND ACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH EMORIAL HOSPITAL EASTON TALBOT SIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY TALBOT ARYLAND **CORDOVA** 1 YES 2 NO STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 0160 LEWISTOWN ROAD 21625 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HOO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indien, Black, White, etc. Never Merried 2 Merried 1 YES 2 NO Specify: Specify: Widowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade College (1-4 or 5+) ementary/Secondary (0-12) 10 -0-FARMER GRAIN THER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) LLIAM F. BLESSING ALICE C. PARKER NFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) EBRA E. BLESSING 10160 LEWISTOWN RD., CORDOVA, MD 21625 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) WOODLAWN MEMORIAL PARK EASTON, MD 21601 3-2 GNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. NHOL 2 MERIFRON CFSZ 200 S. HARRISON ST., EASTON, PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between EDIATE CAUSE (Final **Onset and Death** levole ese or condition 1000 Sc iting in death) DUE TO (OR AS A CONSEQUENCE OF) uentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): y, leeding to immediate e. Enter UNDERLYING SE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): initiated events iting in death) LAST T ii. Other aignificant conditione contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🔀 NO 🗌 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER:
4 Nursing Home 5 Residence 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 MOOA 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 5 Pending 1 YES 2 NO 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. (Check only one) 2 KMEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end manner ee stated.

296. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d, DATE SIGNEO (Month, Day, Year) 12 24769 2718 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

L. THOMAS DIVILIO, M.D., 404 MARVEL COURT, EASTON, MD 21601

JULY DRUCKEN PARALL 31. OATE FILED (Month, Day, Year) FEB 2 8 1995



he hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS. P.O. BOX 68760.

DEFINITION OF THE PROPERTY OF
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Acurs after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)

NAR 1 4 1995

32. REGISTRAR'S SIGNATURE

												01130
	1 - STATE REGISTRAR	STATE OF M					EALTH AND DEATH	MEN1	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) JOSEPH	Boinsteil	^					MO	TE OF DEATH	DAY 3	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 577-09-7801	1 X M 2 🗆 F	6. AGE (In yrs. last	birthday) YRS.		AYS	HOURS MIN.	7. DATE OF BIRTH (Month, Dev. (ber) Dec. 16, 1906 6. BIRTHPLACE (State or Foreign Country) Connecticut				
TOR	99. FACILITY NAME (# not institution, give still 1833 POWDER Mill RESIDENCE OF DECEDENT	-									tgome	
DIRECTOR	100. STATE 10b. COUNTY Maryland Montg			10c. CITY	Silv	on Spring			10d. INSIDE CITY LIMITS? 1 □ YES 2√(∑ NO			
FUNERAL	1833 Powder Mill	Road					ZIP CODE					what country? States
BY FUI	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 F IF YES, GIVE WA UNKNOWN	YES 2 N	MED O	It ye	s, spe	ENDENT OF HISPAI city Cuben, Mexice 2X X NO Specifi	en, Puerl	GIN? (Specify Voto Ricen, atc.)	e or No —	14. RACI Blac Spec	E — American Indian, k, White, etc. thy: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondery (0-12)	ATION	(Gh	re kind of w Do NOT us		ng mos	t of working	-1	16b. KIND OF BU		IDUSTRY	WIII OC
MP	12 17. FATHER'S NAME (First, Middle, Last)	2	Rest	aura	nt Ow	ner			Restau			
	Maurice Bomstein						Eva Gr			n Surname)		
9E	19e. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS (S	treet an	d Number or Rural			wn, State, Z	ip Code)	
2	Beverly Ganley		16	320	B1ack	Ro	ck Road	, Ge	ermanto	wn,	Mary	land 20874
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val trom State	20b. PLACE A cametery, cran	NDDATEO	F DISPOSITIO	ON (Nan	ua of	D	ATE 20c. L	OCATION -	- City or To	
	21. SIGNATURE OF FUNERAL SERVICE LICE	Sau	-07		Mu 22. NAI	rie	ADDRESS OF FA	rbe i	r Funer	al H	ome	
	23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) But to (or as a consequence of): Chronic Hepatitis C											
CERTIFICATION	Sequantially list conditions, if any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated evanta resulting in death) LAST		OR AS A CONSEO	UENCE OF):	(mq					Years
. 1	PART II. Other significant conditions	contributing to	leeth but not re	aultina i	the under		annes aluas la	Dord I	T			
PHYSICIAN: MEDICAL	DIABETES ME			aurung n	tria unidei	ilynig	causa givan m	Part I.	24a. WAS AI PERFO 1 YES	RMED?	240	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
IAN: M	DID TOBACCO USE CONTR	IBUTE TO CAL			S NC		UNCERTAIN	N 🗆				1 TYES 2 NO
SIC		HOSPITAL:	ER/Outpatient 3	DOA	OTHER:	Home	5 Residence	å □ Ot	her (Specify)			
ву рну	27. MANNER OF DEATH 1 Naturel 5 Pending 2 Accident Investigation	26e. DATE OF II (Month, Day		28b. TIME	OF 250	WOR	RY AT		ESCRIBE HOW	INJURY O	CCURED	
	3 Suicide 6 Could not be determined	28e. PLACE OF building, at	INJURY — At horr tc. (Specify)	7e, farm, st	reet, tectory,	office		281, LC	OCATION (Street by or Town, State	and Numbe	er or Rural f	Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER) end <i>m</i> enner es stated,
TO BE C	296. SIGNATURE AND TITLE OF CENTIFIER	B mo					29c. LICENSE NUN 03516					(Month, Day, Year) 3, 1995
F	30. NAME AND ADDRESS OF PERSON WHO MICHAEL SCHOOL	A se Printers	OF DEATH (ITEM	27) (Type,	Print) SP	RIN	6 STRE	EET	SILI	VER	SPRIN	20916

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SILVER SPRING MARYUND

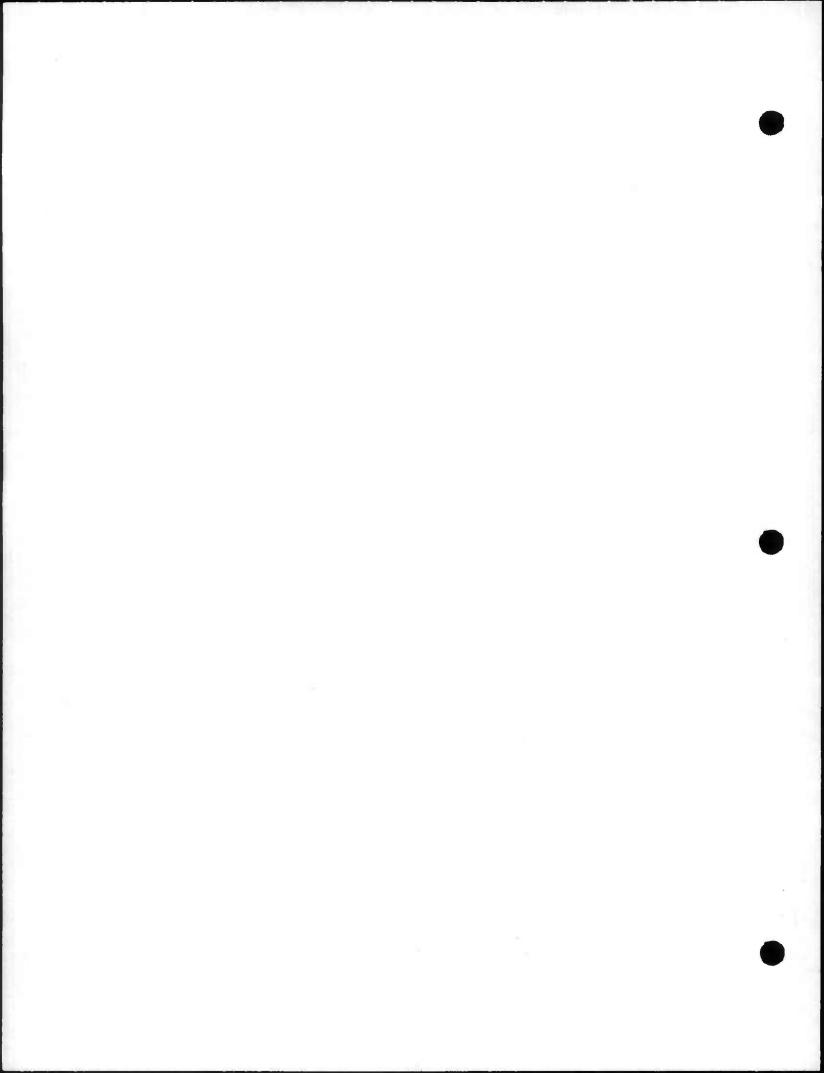
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	or this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	sarked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RE	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requ	TO THE FUNERAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of it	IMPORTANT: If item 28 is marked, or item 23 sho

FOR STATE

	REGISTRAR		C	ERTIF	ICATE (OF DEATH	F	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH			3. TIME OF DE	ATH
		Ruth Wel	ls B	arker			Febru	2777		1 Q Q 5	9:55	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX 8. A	AGE (In yrs. la	at birthday)	IF UNDER 1 Y	EAR IF UNDER 24 HRS.	7. DATE OF				HPLACE (State or	
- 1	579-42-7345	1 M 2 X F	75	YRS.		YS HOURS MIN.	(Month Di	ov Manel	110	Count	'TY')	
	9e. FACILITY NAME (If not institution, give str	met and number					July	29,1	_		nington	ש.נ.
œ						WN OR LOCATION OF	DEATH			UNTY OF D		
₫	Montgomery Genera	I nospital			01r	iey			Mor	ntgom	ery	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			100 0170	, TOWN OR L	00171011						
<u>=</u>											10d. INSIDE CI LIMITS?	TY
		ontgomery		PI	lver S						1 YES 2	X NO
₹	10e. STREET AND NUMBER					101. ZIP CODE			10g. CI	TIZEN OF V	WHAT COUNTRY	
FUNERAL	3300 Solomons Cou	rt				20906				U	SA	
5	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. AI	RMED	13. WAS	DECENDENT OF HISPA	ANIC ORIGIN? (S	pecify Yee	or No-	14. RACE	E — American In	dlan,
	1 Never Married 2 Merried	FORCES? 1 1		NO	If ye	s, specify Cuben, Mexic YES 2 X NO Spec	can, Puerlo Rica	n, atc.)		Black	k, White, atc. //y: White	
B	3 X Widowed 4 Divorced					TEO E MA HO GOOD	-ту.			Speci	my: WIIILE	
COMPLETED	15, DECEDENT'S EDUC	ATION	18e. Di	ECEDENT'S	USUAL OCCU	PATION	16b, KIN	ID OF BUS	INESS/IN	DUSTRY		
ᄪ	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	- SA	alve kind of war. Do NOT us	rork done durir. e retired.)	g most of working						
ᆲ	12		S	ecret	arv		U.S	. Na	vv I)epar	tment	
8	17. FATHER'S NAME (First, Middle, Last)			00100	425	18. MOTNER'S N				- Pul		
	Raymond Boyd Well:	e Sr					1 Mae S		,			
띪	190. INFORMANT'S NAME (Type/Print)	3, 01.										
임	Margaret P. Longo					reet end Number or Rura					00055	
.						on Place	KOCKV11	le,	Mary	Land	20855	
	20a. METNOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo	val from State	competent on		F DISPOSITIO		F	,		- City or To		
	cometery, crametory or other place! 4 Donation 8 Other (Specify) Arlington National Cemetery 3/6/95 Arlington, Virgi										, Virgin	ia
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE				E AND ADDRESS OF F		_				
	Dames &	rad a				ncis J. C						
		amplications that are	Sand About	- Ab D	300	Universi	th Bird	. W .	S11.	Spr.		
	23. PART i. Briter the diseeses, or contained anock, or heert failure. L	ist only one ceuse of	n eech line	9etri. DO N 9.	ot enter the	mode of dying, au	ch aa cardiec	or respi	retory er	reat,	Approxi	nete Batween
	IMMEDIATE CAUSE (Final	0	/		2	reline						nd Death
	disease or condition resulting in death)	Kespe	104	ony	00	erene					34	ays
	With the Control of t	DUE TO (OR		QUENCE OF	E.		9 .	. 0				
z		masse	ul	Yu	luso.	nony	Zul	D.R.C	11		101	Sago
일	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSE	OUENCE OF):	0	RU	-				1
CERTIFICATION	CAUSE (Disease or Injury	Venou	1 0	mul	mele	0515	/ CC				141	Steps
	that initiated events	DUE TO (OR	AS A CONSE	QUENCE OF):	1 0.						
	resulting in death) LAST	Trecent	ma	4	DE	d Co.	rgia	e hi	Del	C-	4Cu	cons
- 14	DART II Other classification and the										1	
8	PART II. Other aignificant conditions	contributing to deal	th but not	resulting in	n the under	lying cause given in	1 Pert I. 24s	PERFOR		24b.	WERE AUTOPSY AVAILABLE PRIO	
8 1	- /							YES 2	. /		COMPLETION OF OF DEATH?	
W W	Esophongus,	kfypenk	24/10	n, C	OPD	, Diane	Kes				1 TYES 2	100
	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEA	TH YE	S NO	☐ UNCERTA	IN W					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLA	CE OF DEAT	H (Check only	one)		-				
	EXAMINER?	HOSFITAL:	Outpetlant 1	DO4	OTHER:							
Ä	27. MANNER OF DEATH	28e. DATE OF INJU		28b. TIME		Home 5 Residence			I HIPW OO	NO LIBERT		
2	1 Natural 5 Pending	(Month, Day, Ye	ar)	INJU	JRY	WORK?	28d. DESCRI	SE NOW IN	IJUHY OC	CURED		
à l	2 Accident Investigation					YES 2 NO						
	3 Suicide 8 Could not be 4 Nomicide datermined	28e. PLACE OF INJ building, etc. (Specify)	ome, ferm, at	ireet, fectory,	office	281. LOCATIO City or To	N (Street e. wn, State)	nd Numbe	r or Rural R	Route Number,	
			_									
2	29a. CERTIFIER (Check only	IAN: To the best of my k	nowledge, de	ath occurred	d at the time,	date end place, end du	a to the cause(a) and men	ner se sta	ted.		
COMPLET	one) 2 MEDICAL EXAMINER) and menner ee	stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	- 2										
出	Muses 1 /a	uless	hus			29c. LICENSE NU	MBEH	- 1	29d. DAT	E SIGNED	(Month, Day, Year	-
2 }	30 NAME AND ADDRESS OF REPORT WATER	COMPLETED ONLO				1005	410		1	1/2	0/75	
	30. NAME AND ADDRESS OF PERSON WHO O. J. LAW ESS	380/	OF THE	AVQ	Liono	1 Dlive	Sel	nes	SA	Zing	Z Cul ?	0806
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S										
	FFR 28 1995	deli Asi										



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

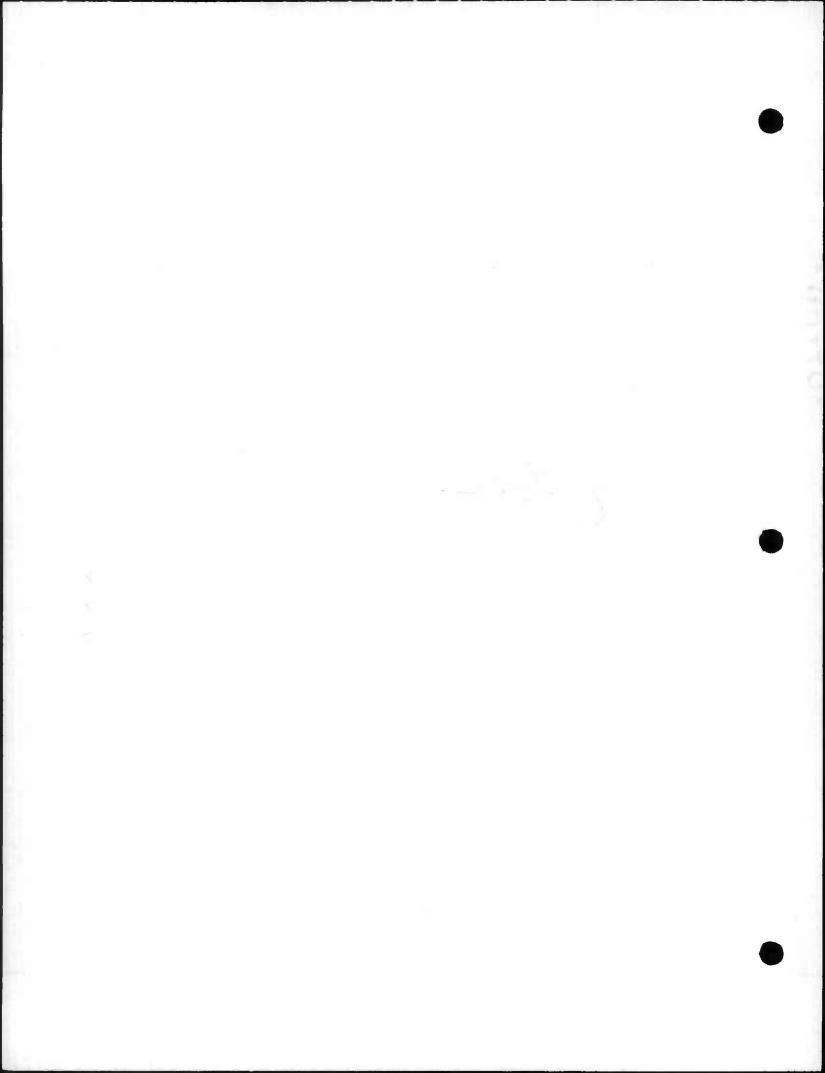
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FOR STATE REGISTRAR

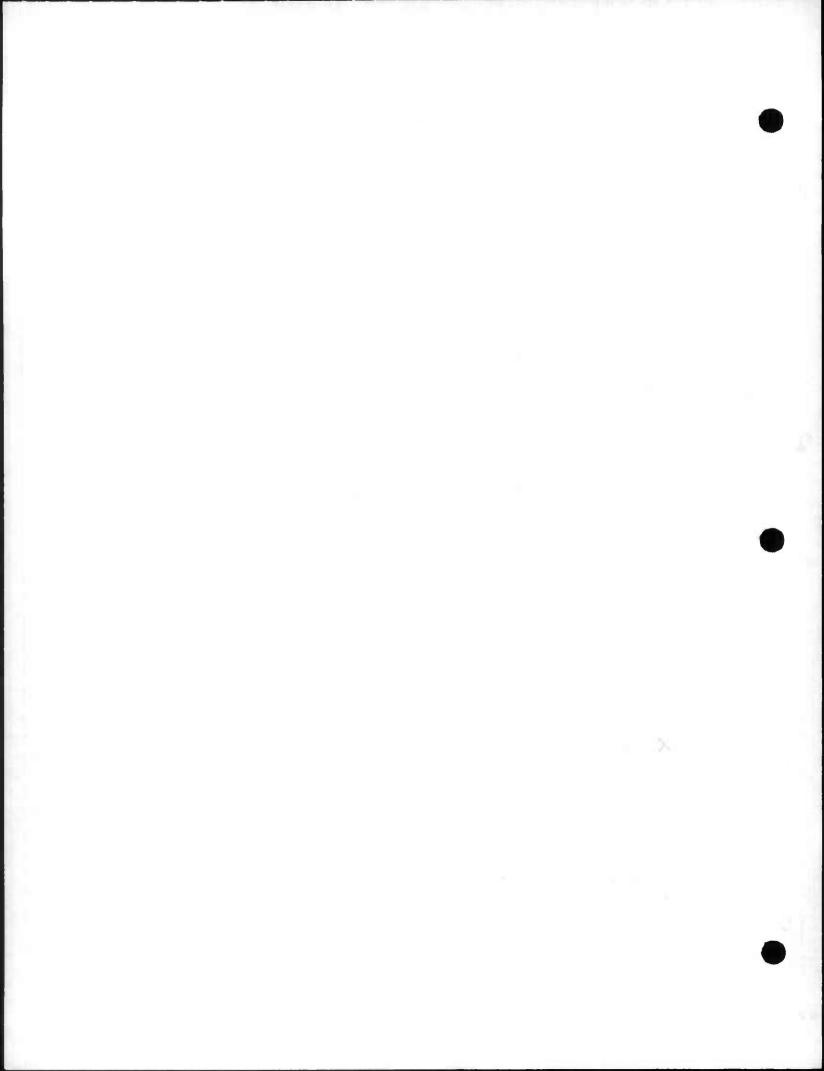
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE	DF DEATH	-		3. TIME	OF DEATH	Ī
	Mary Via Bu	ck								Feb.	Feb. 26, 1995				0 a.	м
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs	s. lest birthday)		R 1 YEAR	IF UNDER	R 24 HRS.	7. DATE C	E BIRTH		6. BIRTI	PLACE (S	tate or Forei	ign
	226-40-1294		1 🗆 M 2 🔀 F	86	YRS.	MONTHS	DAYS	HOURS	MIN.	July	27,	1909	Count	nv)		-
	9e. FACILITY NAME (If not in	stitution, give st	treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF D				INTY OF D			
FUNERAL DIRECTOR	18700 Walker	s Choi	ice Rd.	#608		Gaithersburg Montgom					tgom	ery	_			
EC	10e. STATE	10b. COUNTY	,		10c, CIT	Y, TOWN	OR LOCA	ATION						10d. INS	IDE CITY	
	Maryland	Montgo	omery		Gai	ther	sbur	2							S 2 N	0
AL	10e. STREET AND NUMBER							H. ZIP COD	E			10g. CIT	TZEN OF V			
E	18700 Walker	s Choi	ice Rd.	#608			12	20879				Uni	ted :	State	es	
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S	ARMED	13.	WAS DE	CENDENT	OF HISPA	NIC ORIGIN	(Specify Yes		14. RACE	- Ameri	can Indian	
ВУ	1 Never Married 2 3 Widowed 4 T Divo		IF YES, OIVE V	MAR OR DATES	Muo			S 2 X NO		en, Puerto R fy:	ican, etc.)		Speci	c, White, a	itc.	
	Wi										Whi	te				
COMPLETED	(Specify only highest grade completed) (Give kind of work done during most of working															
١٣	Conege (1-4 or 5 +)										A					
M	orypoologist National Security										Ly A	gency				
	to worten a name (r iss, middie, maken aurname)															
BE	Anderson White Via Lena Maude Harris 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Floute Number, City or Town, Stete, Zip Code)															
2	Richard J. Burk, Jr. 1986. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17800 Vinyard Lane, Derwood, Maryland 20855										0855					
	20e. METHOD OF DISPOSITI	ON			CE AND DATE	OF DISPO	SITION (N		-, -		_					
	20s. METHOD OF DISPOSITION 1 X Burlai 2 Cremation 3 X Ramoval from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery or other place) Monticello Memory Gardens 3/2 Charlottesville											VΑ				
	21. SIGNATURE OF FUNERAL	L SERVICE LICE	ENDEE	n		22.	NAME A	ND ADDRE	SS OF FA	CILITY	ona	1000	20071	110,	VII	
	· \	. 7 "	(A)	/						Home						
\neg	23. PART I. Enter the di	sekses or o	omplications the	it caused the	death Do	1(JE.	Deer	Pa	rk Dr	., Ga:	ither	sbur			
ı	snock, of he	ert fallure. L	List only one ceu	se on eech	line.	iot eine	i tile inc	oue or dy	ing, suc	m aa caru	ac or reap	iratory ar	reat,	inte	proximate erval Betv	ween
	IMMEDIATE CAUSE (Fine) disease or condition Management of the condition o											set and D)eath			
	resulting in death)	→		OR AS A CON												
-		_	Coronar			,-	0								2 ye	are
CERTIFICATION	Sequentially list conditi	ona,	DUE TO	(OR AS A CON	ISEQUENCE O	F):								1	Z ye.	ars
8	cause. Enter UNDERLY!	NG	Stroke											>	2 ye	ars
E	CAUSE (Disease or Inju thet initieted events	"		(OR AS A CON	ISEQUENCE O	F):								1		
	resulting in death) LAS		. Hyperte	ension										>	2 ye	ars
- II	PART II. Other eignifice	nt conditions	contributing to	deeth but no	ot resulting	n the u	nderlyln	O COURS O	alven le	Dort I	24a, WAS AN	ALITTORNAY	-			
MEDICAL	Congestive				or resuming			g couse (giveii iii	7 8111.	PERFOR		240.	MAILABLE	TOPSY FIND E PRIOR TO ION OF CAU	
	Oongeserve	neare	Tallule							-	1 YE\$ 2	XNO		OF DEATH	17	
	DID TOBACCO U	SE CONITE	IRLITE TO CA	LISE OF D	EATL V	c \Box	NO F	T LINE	ERTAI					1 TYES	2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO		IDUIL IU CA		LACE OF DEAT				CKIAI	Т						
SIC	EXAMINER?		HOSPITAL:		1	OTHE	R:	_	-14	8 🗆 Other						\neg
H	27. MANNER OF DEATH		26e. DATE OF	INJURY	28b. TIM	E OF	28c. IN.	JURY AT	sidence		(Specify)	NJURY OC	CURED			-
		Pending nvestigation	(Month, D	ay, Year)	INJ	URY M	WC	ORK? YES 2	NO							- 1
à l	3 Sulette	Could not be	28s. PLACE O	F INJURY - A	t home, farm, s	street, fac	tory, offic	00		28f. LOCA	TION (Street a	and Number	or Rural A	loute Numb	oer,	\dashv
ΨI		letermined	bullaing,	atc. (Specify)						City or	Town, State)					ı
۱۳	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.															
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.															
	296. SIGNATURE AND PITLE		. 1	1												
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요	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH	ITEM 27) (Type	Print)	_		15	7/	12		гер.	2/,	1995	-
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted to be filed within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT. If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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000	578-80-375	9	5. SEX	6. AGE (In yrs. let	st birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DAT	E OF BIRTH (nth, Day, Year)	956		
TOR	99. FACILITY NAME (If not in Suburban Ho	spital	reet and number)			Bethe	N OR LOCATION OF	DEATH			nty of oe taome	
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY			10c. CIT	Y, TOWN OR LO	CATION					10d. INSIDE CITY
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FUNERAL	100. STREET AND NUMBER 12517 Arbor	View	Terrace				101. ZIP CODE 20902					States
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BE	199. INFORMANT'S NAME (7)	LOU ype/Print)	Baer,		_	ADDRESS (Stree	Fredri		mber City or Town		Biede	rman
입	Cheryl Rich	ards	(Wife)			as #10			indo, only or lowe	7, Otato, 24	Coody	
	20e. METHOD OF DISPOSITION 1	n 3 🗆 Remo	val from State	cemetery, cre	matory or of	of disposition (ther place) e Crema		3-			City or Tow	
	21. SIGNATURE OF FUNERA	L SERVICE LICI	ENSEE /	1 011000	apour	22. NAME	AND ADDRESS OF I	ACILITY			110,	MD
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	23. ANT I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disesse or condition resulting in death)	eart fellura. L nai	ist only one caus	se on each line	o.				rdiac or respi	ratory srr	est,	Approximate interval Between Onset and Death
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ERTIFICATION	cause. Enter UNDERLYI CAUSE (Disease or Inju that initiated events resulting in death) LAS	ry s	DUE TO (OR AS A CONSE	OUENCE OF):						
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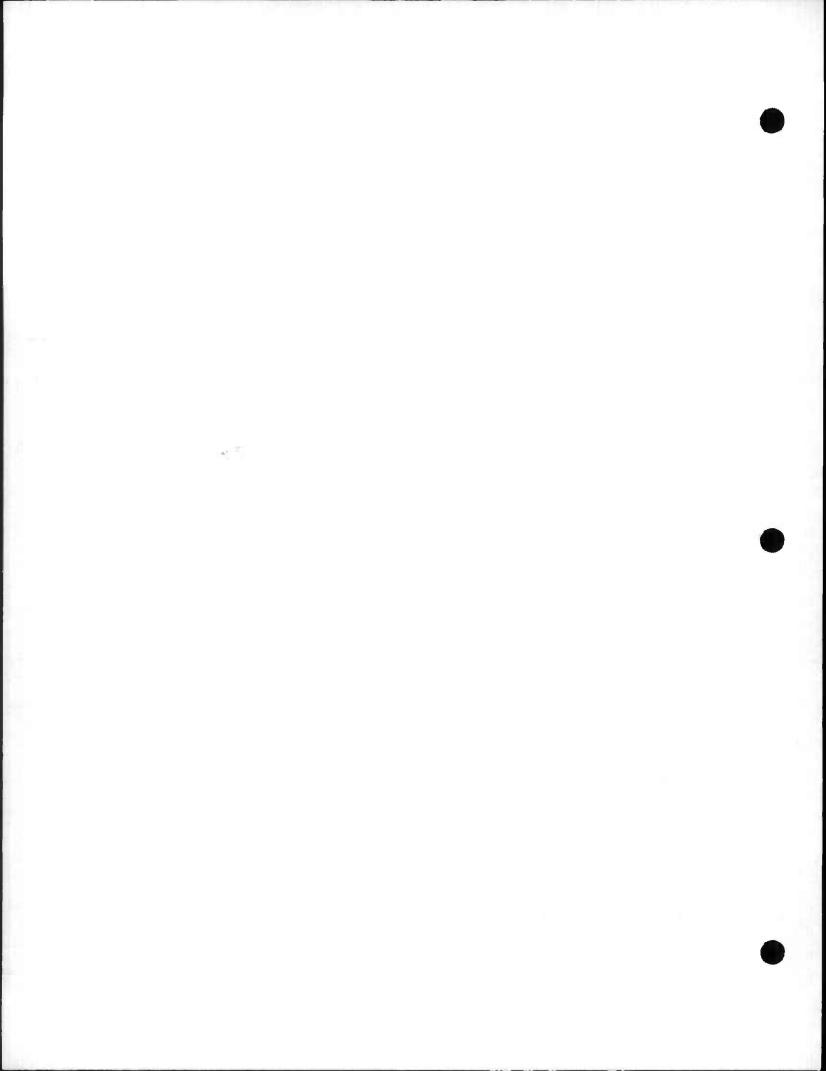
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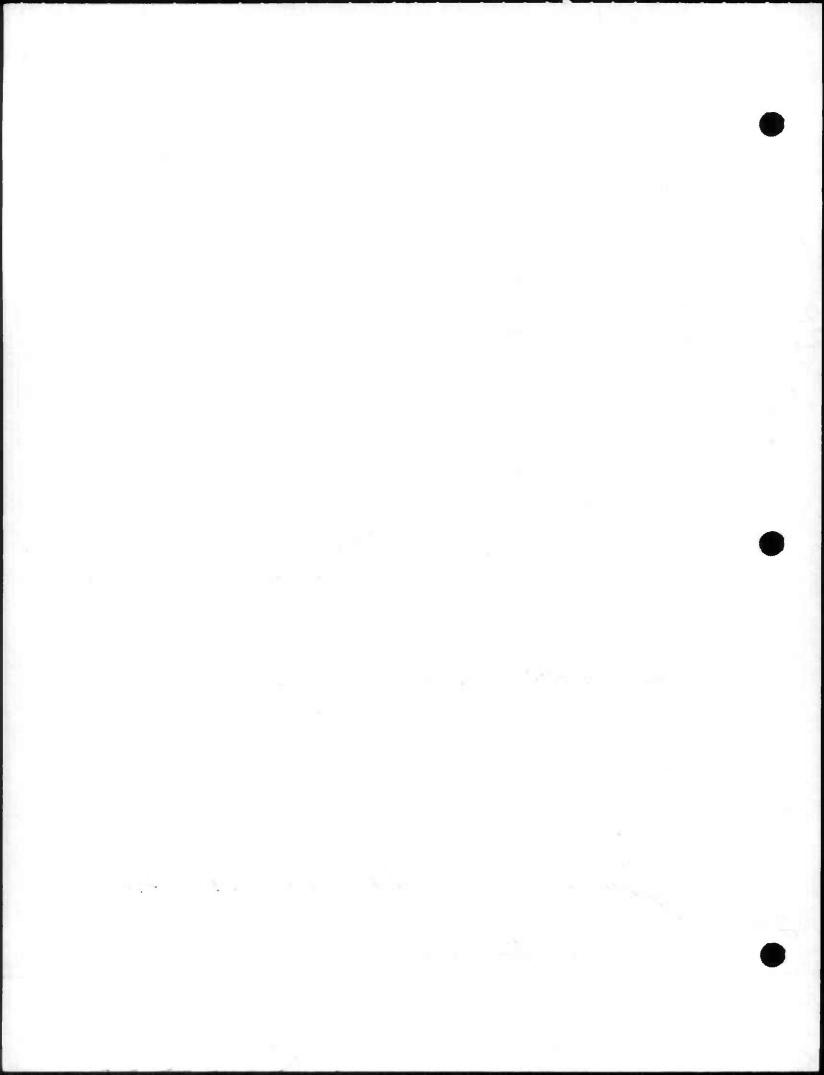
32. REGISTRAR'S SIGNATURE



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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTM CERTIFICA	ENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH						
	EVELYN	BLUE		FEB. 22,1995	YEAR 5:37 P M						
2	4. SOCIAL SECURITY NUMBER 060-10-3811	1 ☐ M 2 ☒ F 85 YRS. MON	NOER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 6, 1909	8. BIRTHPLACE (State or Foreign Country) New York						
shou	9e. FACILITY NAME (If not institution, give st	4	CITY, TOWN OR LOCATION OF DE		DUNTY OF DEATH						
1, 2, 3 s CTOR	Carriage Hill Nur	sing Center E	ethesda	Mon	tgomery						
t. Pages 1	10e. STATE 10b. COUNTY	10c. CITY, TO	WN OR LOCATION		10d. INSIDE CITY LIMITS?						
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RAI	100. STREET AND NUMBER 500 23rd Street	N LI	10f. ZIP CODE		ITIZEN OF WHAT COUNTRY?						
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RYL, and be a set at a	Alexander Gair	Blue	Alma	Smith							
, MARYLAND be retained by the hospit e 5 should be detached notified at once.	19a. INFORMANT'S NAME (Type/Print) Robert B. Bechtold 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Lighthouse Road Scituate, MA 02066										
ORE, s 6 may be ector, page	20a. METHOD OF DISPOSITION 1 🔀 Burlel 2 Cremation 3 🗆 Remo	20b. PLACE AND DATE OF DIS- cemetery, cremetory or other p		DATE 20c. LOCATION	— City or Town, State						
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RECORDS, P.O. BOX 68760 requires that the death certificate be executed within 24 hours after the signed by the attending physician and completely filled in by the other than the property of remove shows any injury, or other traumatic event, the medical to MEDICAL CERTIFICATION	iMMEDIATE QUSE (Final disease or condition resulting in death) Sequentially list conditions, if sry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CONTRIBUTION OF AS A CONSEQUENCE OF):	a underlying cause given in		<i>\rightarrow</i>						
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DIVISION OR ATTENDING DIRECTOR: After hours after deati Item 28 is ma	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Yown, Stele)										
로 크인트 블	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner es stated. MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end manner es stated.										
TO THE HOSPITAL TO THE FUNERAL De fled within 72 IMPORTANT: II	29b. SIGNATURE AND TITLE OF CERTIFIER	Atoster Wa	29c. LICENSE NUM 29c. LICENSE NUM	BER 29d. D/	ATE SIGNED (Month, Day, Year)						
50	James J. Foster	M.D. 5530 WI AVE #92		MD.20815							
0	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE									
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eath.	uneral		TANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 02 2 3:18PM Μ. **BROWN GENE** 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign DAYS 1 M 2 X F 579-34-9193 68 YRS 9 Jan. Washington D.C 9e. FACILITY NAME (If not inetitution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Prince George's Hospital Cheverly P.G. RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. P.G. Greenbelt TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 7 - B Hillside RD. 20770 U.S.A. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify: White 87 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EOUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surneme) Eugene Decker 8 Bessie 19e. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Rouger) Number, City or Yours, State, Zip Code)
12701 Brandywine RD. Brindsyvine, MD. 20613 2 Sarah Brown 20e. METHOD OF DISPOSITION
1 ☐ Buriel 2 🎇 Cremetion 3 ☐ 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State cometery, cromatory or other place) Chambers Crematory 4 Donation 5 Other (Specify) 27 Riverdale, MD. 22. NAME AND ADDRESS OF FACILITY $W_\bullet W_\bullet {\rm Chambers\ Co.}\ {\rm Inc.}$ 21. SIGNATURE OF FUNERAL SERVICE LICEN 5801 Cleveland Ave. Riverdale, MD. 20737 23. PART I. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or hasrt failure. List only one cause on each line. **IMMEDIATE CAUSE (Final Onset and Death** disease or condition metastate 3 MOS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Usud become OF DEATH? PHYSICIAN:

25. WAS CASE REFERBED TO MEDICAL	26. PLA	CE OF DEATH (Che	ck only ofe)		
1 YES	HOSPITAL:	ОТН		6 Other (Specify)	
MANUER OF DEATH 5 Pending Investigation	DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. OEŞCRIBE NOW INJURY OCCURED	
3 Suickle 8 Could not be determined	26e. PLACE OF INJURY — At he building, etc. (Specify)	ome, farm, street,	actory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

edge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. tion end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee stated. IEO (Month.

26

PLETED CAUSE O DEATH (ITEM 27) (Type, Print)

32. BEGISTRAR'S SIGNATURE

. The state of the s y and the State of

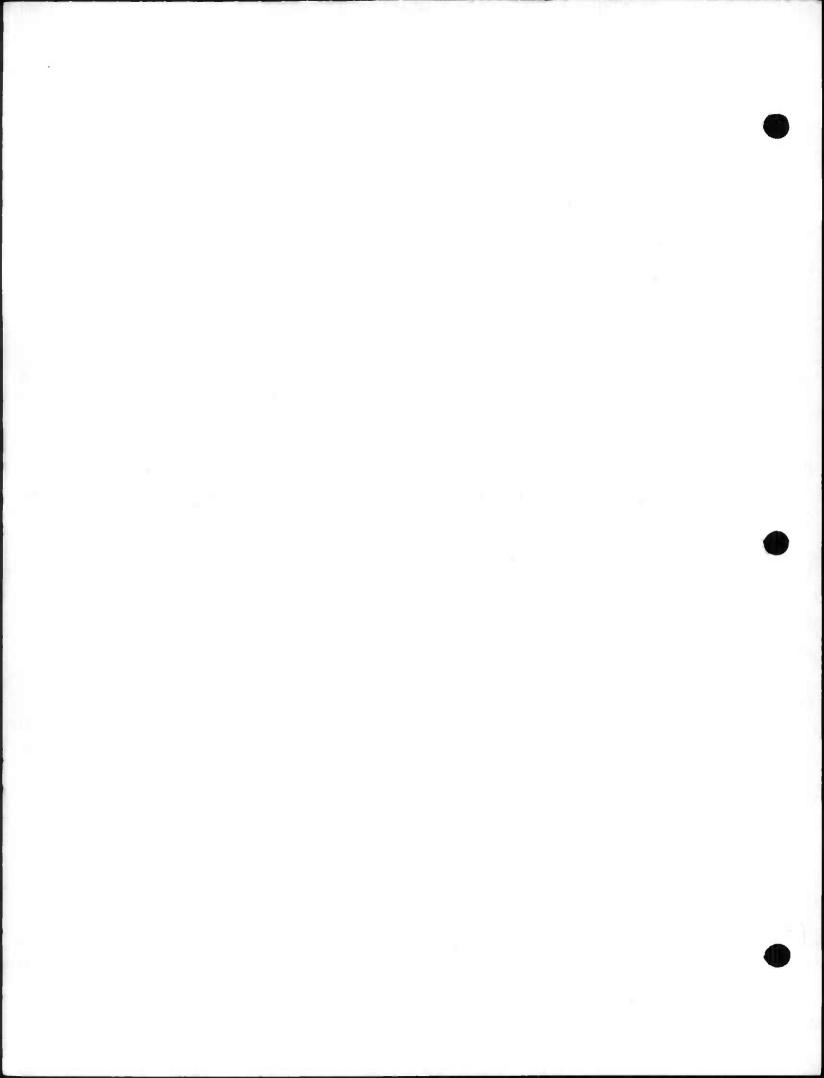
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL	HYGIEN REG. NO				
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O				3. TIME OF DEAT	Н
- 19	Mozelle	e Butterworth				MONTH	D	8,199	YEAR 5	7:05	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH			PLACE (State or Fo	
1	456-28-2773	1 🗆 M 2 💢 F	70 YRS.	MONTHS DAYS	HOURS MIN.	(Month,	Day, Year) 16,1	- 1	Country	1)	· u·g//
	9a. FACTLITY NAME (If not institution, give	street and number)		9b. CITY, TOWN	OR LOCATION OF D		10,1	9c. COUNT		exas	
DIRECTOR	Collingswood Nurs	sing Center		Rockv						gomery	
E C	10e. STATE 10b. COUNT	TY	10c. CITY,	TOWN OR LOCAT	TION				-	10d. INSIDE CITY	
늅	Maryland Mo	ontgomery		Rocky	ille				- 1	LIMITS?	
	10e. STREET AND NUMBER				. ZIP CODE			10a. CITIZE		HAT COUNTRY?	
ER	299 Hurley Avenue	5			20850					States	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN?	(Specify Yes		_		00
	1 Never Married 2 Married	FORCES? 1 YES		If yes, sp	ecify Cuban, Mexico	en, Puerto Ric	can, etc.)		Specifi	— American India White, atc.	~,
ВУ	3 🔀 Widowed 4 🗌 Divorced			""	LA No opeca	·y.			Specin	White	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S U	SUAL OCCUPATION MICH done during mo	ON set of working	16b. I	UND OF BUS	SINESS/INDU	STRY		
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)							
₹	-	1	Informat	ion Ana	1yst	Na.	tiona	1 Geo	grap	phic Soc	iety
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Mi	ddle, Maiden	Surname)			
BE		ce Wilkins			Wi1	lla Re	eves				
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	and Number or Rural	Route Numbe	r, City or Town	n, Statu, Zip C	ode)		
-	Sherry D. Morris				, Raleig					27604	
	20a. METHOD OF DISPOSITION 1 ☐ Burlet 2∑☐ Cremation 3 ☐ Ran	novel from State	. PLACE AND DATE OF	DISPOSITION (Ne	me o2/23/9	5 DATE	20c. LO	CATION — CI	ty or Tow	vn, Stata	
	4 Donation 5 Other (Specify)	M	netery, cremetory or othe ontgomery	Cremat			Beth	esda,	Mar	yland	
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		22. NAME A	D ADDRESS OF FA	CILITY RO	bert	A. Pu	mphr	ey Fune	ral
	Michele 4	1. Nulla	M00348	Home/	Rockvill	e, In	c., 3	00 W. 850-28	Mon	ntgomery	Ave
	23. PART i. Enter the diseases, or	complice ons thet cause	d the death. Do no							Approxime	ta
	shock, or heart fellure. IMMEDIATE CAUSE (Finel	. List only one cause on e	ach line.			1100 0 1000000				interval Be	tween
	disease or condition	Cardio-pu	lmonary A	rroct						minute	
ı	resulting in death) a. Cardio-pulmonary Arrest Due to (or as a consequence of):					Illiace	5				
-	Cerebro-vascular Infarction 7 years						rs				
2	Sequentially list conditione, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):								
8	cause. Enter UNDERLYING CAUSE (Disease or injury	Diabetes								20 yea	rs
Ē	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							+	
CERTIFICATION	resulting in death) LAST	d. Hypertens.	ion							20 yea	rs
	PART II. Other eignificant condition	ns contribution to death h	ust and socialized to			T			_		
SAL	THE STATE OF THE PARTY OF THE P		of not resulting in	the underlying	g ceuse given in	Part I. 2	PERFOR			WERE AUTOPSY FIF AVAILABLE PRIOR 1	o
						— [·	YES 2	K) NO		COMPLETION OF C OF DEATH?	AUSE
2						_				1 - YES 2 X N	0
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL									<u></u>	
힐	EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch						
₹	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp			e 5 🗆 Residence						
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME	WO WO	RK?	28d. DESC	RIBE HOW IP	JURY OCCU	RED		
B	2 Accident Investigation	25. DI ACE OF IN HIDY	100		rES 2 NO						
	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY building, atc. (Spec	At nome, farm, str city)	eet, factory, office		28f. LOCAT City or	ION (Street a Town, State)	nd Number or	Rural Ro	oute Number,	
Li,	20. 0007/000										
AP.	29a. CERTIFIER Check only one) CERTIFYING PHYS	SICIAN: To the best of my know	ledge, death occurred	at the time, date	and place, and due	to the cause	(s) and man	ner as stated			
COMPLETED	2 MEDICAL EXAMIN	ER: On the beals of examination	n and/or investigation,	In my opinion, d	eath occured at the	time, data ar	nd placa, and	d dun to the	cause(a)	and manner as st	nted.
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	",, 1			29c. LICENSE NUI	MBER		29d. DATE S	IGNED (Month, Day, Year)	
2	Non	19-1	رروف	~	D14660)		Feb:	ruar	y 18,19	94
-	30. NAME AND ADDRESS OF PERSON WI		*								
	Ronald E. Greger,	M.D., 15001	Dufief M	ill Roa	d, Gaith	ersbu	rg, M	aryla	nđ	20878	
	31. DATE FILED (Month, Day, Year) FFR 28 1995	2. REGISTRAR'S SIGN	Ravdall								
	FFB & 0 1995	Jame minner									

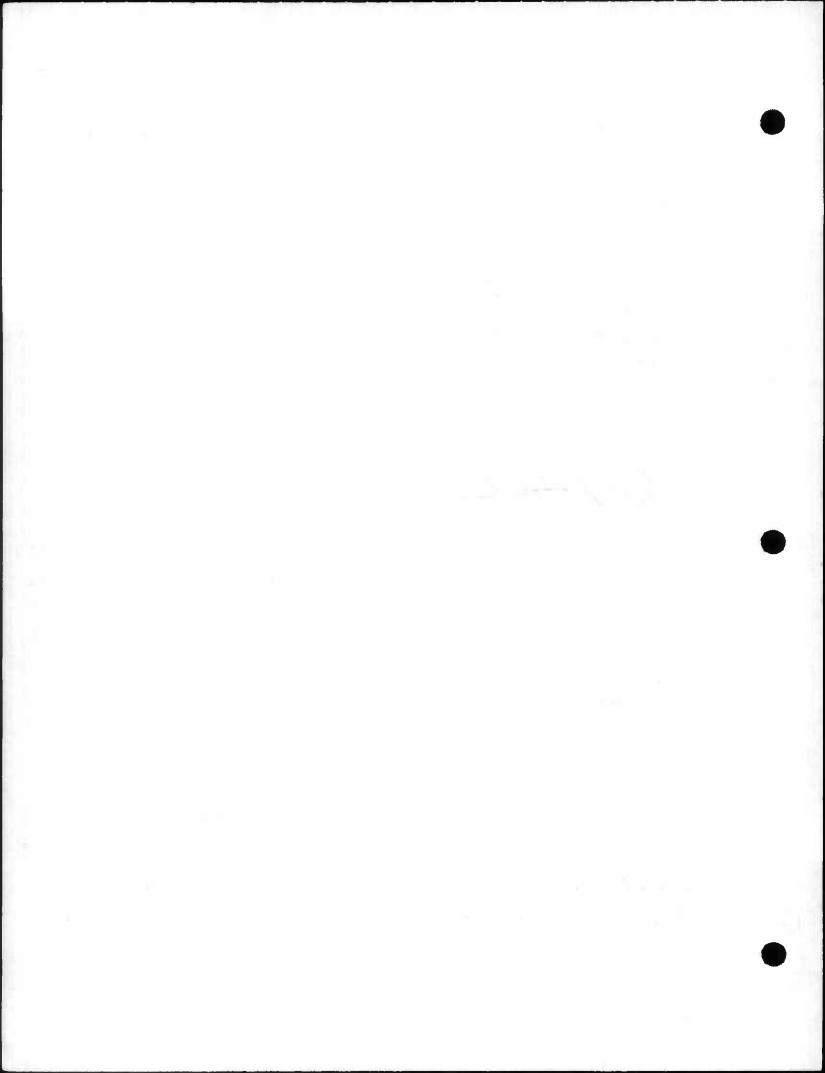


leath. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	TO BE COMBIETED BY BUYCICIAN. MEDICAL CERTIFICATION
i examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
val.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
the funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
er death, Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp
DOLLEY WALL TANK	

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND ME	ENTAL HYGIEN		0,700	
- 8	1. DECEDENT'S NAME (First, Middle, Las				2	. DATE OF DEATH		3. TIME OF DEATH	
1 3	ELIZABET	T/4 S.	Bo	UVE	- /	EBURDRY		50145 m	
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR		DATE OF BIRTH	8. BI	IRTHPLACE (State or Foreign	
	137-28-5929 9a. FACILITY NAME (If not institution, giv		79 YRS .	MONTHS DAYS		(Month, Day, Year) July 3, 1	915 N	ew Jersey	
ac .					OR LOCATION OF DEATI	н	9c. COUNTY O	OF DEATH	
DIRECTOR	Suburban Hosp	Ital		Ве	thesda		Mont	gomery	
RE	10a. STATE 10b. COU		10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?	
		ontgomery		Bethe	sda			1 TES 2 X NO	
FUNERAL	104. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?	
N N	4949 Battery L				20814			d States	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES	2 X NO	13. WAS DEC	ENDENT OF HISPANIC -	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No- 14. R	IACE — American Indian, Black, White, alc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 🗌 YES	2 NO Specify:		S	Specify: White	
요	15. DECEDENT'S E	DUCATION	16a. DECEDENT'S	USUAL OCCUPATIO	ON .	16b. KIND OF BUS	I I I I I I I I I I I I I I I I I I I		
COMPLETED	(Specify only highest gra	College (1-4 or 5+)	(Give kind of w life. Do NOT us	ork done during mo retired.)	st of working				
₽ F		1	Secre	tary		Univ	versity		
8	17. FATHER'S NAME (First, Middle, Lest)				16. MOTHER'S NAME	(First, Middle, Maiden	Surname)		
BE	Fitzhugh C. Spe	er			Elizabe	th Burre	11		
5	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural Rout)	
-	Barbara B. Samps				ay Rd., Br		e, MD	20833	
	20a. METHOD OF DISPOSITION 1 Burlal 2 CCremation 3 Re	moval from State 20t	PLACE AND DATE Of	rer place) Feb	26, 1995 orium, In	DATE 20c. LO	CATION — City or		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	LICENS F	ontgomer		D ADDRESS OF FACILI		thesda,	Maryland	
	10,1	1 1	M00198	Robert	A. Pumph	rey Funer	cal Home	e/ Inc. MD 20814-3501	
	1 aug	Tour		7557 W	lisconsin	Ave. Beth	nase, nesda,	MD 20814-3501	
	23. PART I. Enter the diseases, o ahock, or heart fellung	r complications that ceuse e. List only one cause on e	d the death. Do nech ilne.	ot enter the mo	de of dying, such a	a cardiec or respi	ratory arreat,	Approximate interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	Λ.			C			Onset and Death	
1	resulting in death)	a. M VLT	CONSEQUENCE OF	M	FAILUR	6		2 DAYS	
z								SMAXC	
CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate	DUE TO (OR AS	CONSEQUENCE OF):	10/11/3			00112	
S	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A DUE TO (OR AS A	AL	HEMA	TOMA			5 DAXS	
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):				- x 440	
E E		d. FALL						S DATIS	
AL	PART II. Other algnificant condition	one contributing to death b	ut not resulting l	the underlying	ceuse given in Par	rt I. 24a. WAS AN	AUTOPSY :	24b. WERE AUTOPSY FINDINGS	
MEDIC	LIVER DISI	EASE				1 TYES 2		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME	COUMADIN	THERAP						1 YES 2 NO	
ä	DID TOBACCO USE CON	TRIBUTE TO CAUSE C	F DEATH YE	S I NO I	UNCERTAIN				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT						
PHYSICIAN:	1 YES 2 NO	1 Nonpatient 2 ER/Outs	atlent 3 DOA	OTHER: 4 Nursing Home	5 - Residence 6 -	Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	28b. TIME	RY WO	RK?	d. DESCRIBE HOW IN	JURY OCCURED		
B	2 Accident Investigation		75		ES 2 NO	1-616			
G	3 Suicide 8 Could not b- 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spec	oifv) e	M G	26	I. LOCATION (Street a City or Town, State)	nd Number or Run	rel Route Number,	
COMPLET	29a. CERTIFIER 1 CERTIFYING BUY	/PICIAN, To the best of an income				# 10	e mi securo		
M P	(Check only one) 2 MEDICAL EXAMI	SICIAN: To the best of my know NER: On the basis of examination	neage, death occurre n and/or investigation	In my opinion de	and place, and due to 1	the cause(s) and man	ner as stated,		
8	250. SIGNATURE AND TITLE OF CERTIF			4					
8	The same	AMu.	11/1	1	29c. LICENSE NUMBER	90	Z9d. DATE SIGN	NED (Month, Day, Year)	
0	30. NAME AND ADDRESS OF PERSON W	THO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	2010	17	(CBC)	KITY 25 TO	
	FRANCIS C. M	HULE 10218	Knn	U COO. N.	Ro B-	THESL	ed Al	21812	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		-0,0	7 7 0		11012	70011	
	FEB 28 19	95 Jalia David	war Rardall						



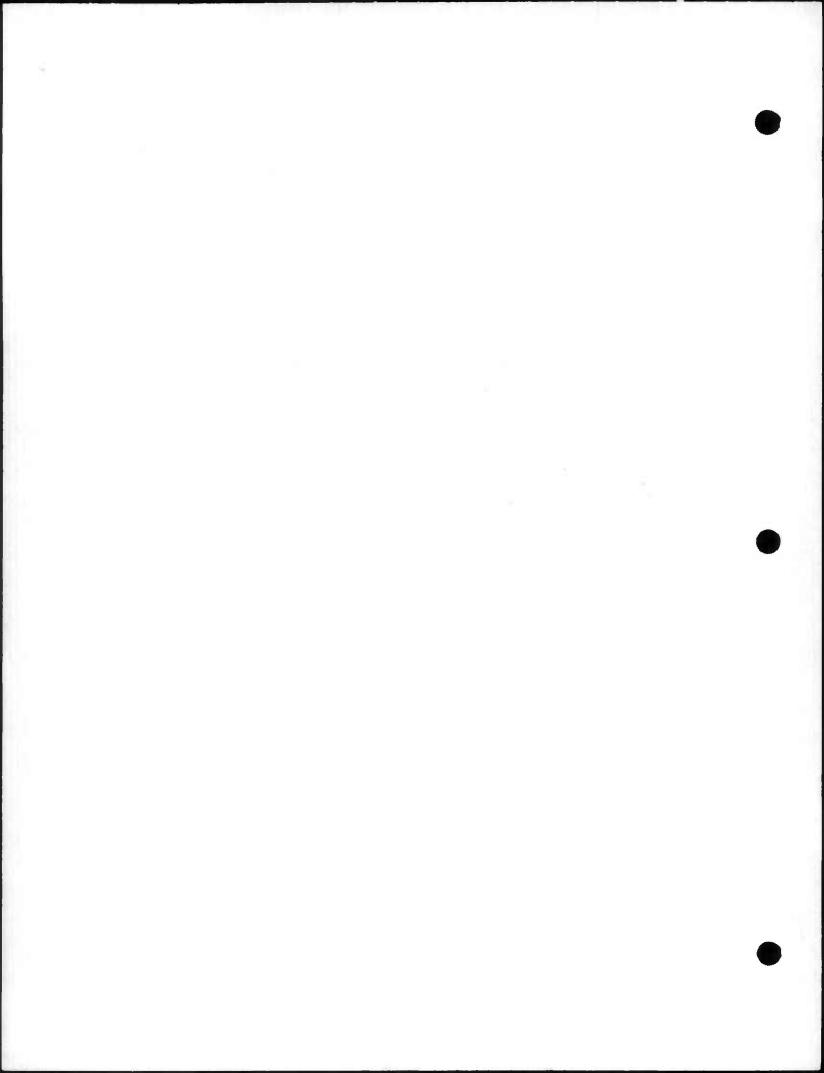
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Panes 1 2 3 should	fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law rec	TO THE FUNERAL DIRECTOR: After this certificate has been	be filed within 72 hours after death with the State Dept. of	IMPORTANT: If item 28 is marked, or item 23 shi

	Amended #17 1 - FOR 1 - REGISTRAR	3/28/95 STATE OF MARYLAND	MRT DEPARTMEN ERTIFICAT	IT OF I	Mon to	MENTAL HYGIEN	E 8-50	4739
	1. DECEDENT'S NAME (First, Middle, Last)		LITTI IOAT		DEATH	2. DATE OF DEATH		3. TIME OF DEATH
	Helen Adams Bu	ırnell				February 2		25 1:49 PM
		. SEX 6. AGE (In yrs. le:		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	220 30 03/3	□ M ² 🔀 F 82	YRS. MONTHS	DAYS	HOURS MIN.			Washington, DC
~	9a. FACILITY NAME (If not institution, give street		9b. CIT	Y, TOWN	OR LOCATION OF D	EATH	9c. COUNTY	
10	18700 Walkers Choi	ce Road, #726		Gait	hersburg	1	Mor	ntgomery
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCA	TION			10d. INSIDE CITY
	Maryland Monto	jomery	Gaith	nersk	ourg			LIMITS?
MA	10e. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZE	OF WHAT COUNTRY?
FUNERAL	18700 Walkers Cho				20879			ed States
	11. MARITAL STATUS 12 1 Never Married 2 Married	P. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2		If yes, sp	CENDENT OF HISPAI ecify Cuban, Mexica	NIC ORIGIN? (Specify Yar in, Puerto Rican, etc.)	or No- 14	. RACE — American Indian, Black, White, atc.
ВУ	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DATES		1 TYES	2 NO Specif	y:		Specify:
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con		ECEDENT'S USUAL	OCCUPATION	ON	16b. KIND OF BU	SINESS/INDUS	White
E		College (1-4 or 5 +)	Give kind of work done b. Do NOT use retired.	during mo	ost of working			
MP		2	Homemak	er		Own	Home	
	17. FATHER'S NAME (First, Middle, Last)	. 01				ME (First, Middle, Maiden		
BE	Thomas Benjamin E					or Marshal		
2	19b. MAILING ADDRESS (Street and Number or Rural Route Nur							
	1 4223 East West Highway, Bethesda, Maryland 2001							
	20s. METHOD OF DISPOSITION 1 Burlal 2 X Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of 1, 1995 20c. LOCATION - City or Town, State 20c. LOCATION - City or Town, State Montgomery Crematorium, Inc. Bethesda, Maryland							
	21. SIGNATURE OF FUNERAL SERVICE LICENS	Mullentan	100831 F Mence E	NAME AIRODET	t A. Pum	curv iphrey Fune Ty Chase, I	ral Ho	ome/ 557 Wisconsin 0814-3501
	23. PART i. Enter the diseases, or com	pilications that caused the de	eeth. Do not ente	r the mo	de of dying, suc	h es cardisc or respi	ratory arrest	, Approximate
- 1	IMMEDIATE CAUSE (Final	only one cause on each line						Interval Between Onset and Death
	disease or condition resulting in death) s	Cardia	An	est	1			1 hour
	DUE TO (OR AS A CONSEDUENCE OF):							
RTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING							
음	CAUSE (Disease or injury that initiated events	OUE TO (OR AS A CONSE	DUENCE OF):					
	resulting in death) LAST							
2	PART ii. Other algnificent conditions of	ontributing to death but not -	reculting in the u	and and side.		But I as una un		
PHYSICIAN: MEDICAL	Change Blos to	twee so long	Variation of the	O- h	y couse given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
E	Atu Fili M	the Colon	Car = 1	21		1 🗆 YES 2	⊠ ND	DF OEATH?
2	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF DEA	TH YES	NO K	UNCERTAIN	<u>-</u>		1 🗌 YES 2 🔀 ND
NA.	25. WAS CASE REFERRED TO MEDICAL		E DF DEATH (Check		OITCERIAII	10		
SIC		OSPITAL: Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)						
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJ	URY AT	28d. OESCRIBE HOW II	NJURY OCCUR	ED
B	1 Natural 5 Pending 2 Accident Investigation		М	1 🗆 1	WORK? YES 2 ND			
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE DF INJURY — At ho building, atc. (Specify)	ome, term, atreet, fac	ctory, offic	•	28t. LOCATION (Street a City or Town, State)	nd Number or I	Rural Route Number,
COMPLETED								
MP	(Check only	N: To the best of my knowledge, de						
	29b. SIGNATURE AND TITLE OF CERTIFIER	n the basis of examination and/or i	ervestigation, in my	opinion, d				
BE	290. STURNATURE AND TITLE OF CERTIFIER	Zell MA			29c. LICENSE NUM	1900		GNED (Month, Day, Year)
D29300 Fe					Febr	uary 27, 1995		

29a. CERTIFIER (Check only one) on and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) February 27, 1995 D29300

M.D. Robert L. Gold, 15225 Shady Grove Road, #201, Rockville, MD

31. DATE FILED (Month, Day, Year)
FFR 28 1995 32. REGISTRAR'S SIGNATURE



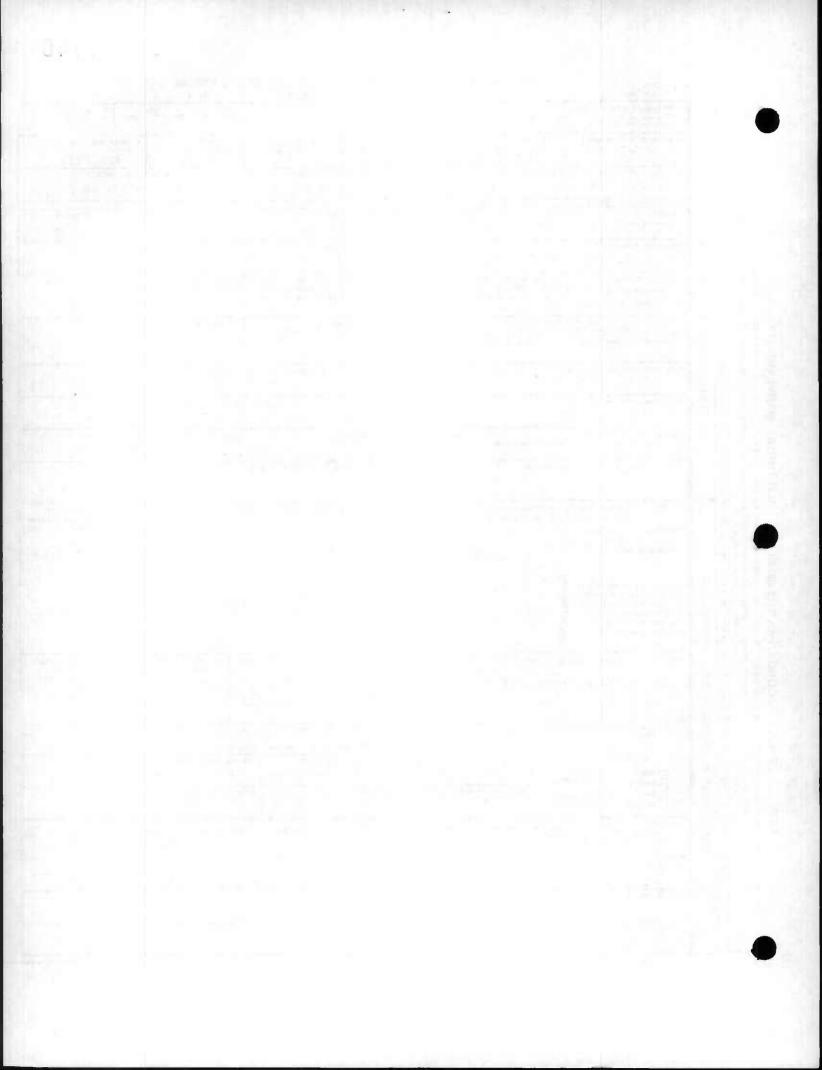
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Durs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYL REGISTRAR	AND / DEPARTI			MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Jeremiah J. Butler				2. DATE OF DEATH Mattch 8, 2	995 YEAR	3. TIME OF DEATH 12:54PM	
0	089-05-3869 ¥□ M 2 □ F 8		F UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OCt. 23, 190	7 a. BIRT	NPLACE (State or Foreign try) WYORK	
TOR	90. FACILITY NAME (W not institution, give street and number) Meridian Nursing Ctr.	9		nsville	EATH	9c. COUNTY OF Balt.	imore	
DIRECTOR	100. STATE 100. COUNTY Maryland Howard	The service of Education				10d. INSIDE CITY LIMITS? 1 YES 2 X NO		
FUNERAL	3004 N. Ridge Road, Apt. 225		101	21043		10g. CITIZEN OF U.S.	F WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IF FORCES? 1 AYES IF YES, GIVE WAR OR D. W. W. T.	2 ND	If yes, sp		NIC ORIGIN? (Specify Yes on, Puerto Rican, atc.) fy:	or No— 14. RAC Blac Spec	E — American Indian, ck, White, etc.	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ()—8	16e. DECEDENT'S US (Give kind of work life. Do NOT use in Agent	k done during mo-	N It of working	Steam F:		Injon	
BE COM	17. FATHER'S NAME (First, Middle, Last) Joseph Butler	J			ME (First, Middle, Maiden S Mackey		JILON	
TO	19a. Informant's name (Type/Print) Bertha Butler				Apt. 225, E		City,Md.2104	
		PLACE AND DATE OF E etery, crematory or other Garrison	Forest		S 3-13 Owin	ATION — City or T		
	23. PART I. Entar the diseases, or complications that caused	Neh 1	enter the mo	to of dulan our	th an anadlan ar arcala		Approximata	
	IMMEDIATE CAUSE (Final	Andre congression or s		S. Graying, sac	ni ea cardiac di 19aphi	atory arrest,	Interval Between Onset and Daath	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in dasth) LAST							
AL	PART II. Other significant conditions contributing to death be a second of the second	ut not resulting in	the underlying	cause given in	Part i. 24a. WAS AN A PERFORM 1 YES 2	ED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO	
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	0	26. PL	ACE DF DEATH (C)	seck only one)			
BY PHYSICIAN: MEDIC	1 PRES 2 RevOutp 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident (Month, Dey, Year)	5 Residence JRY AT RK? ES 2 NO	6 Other (Specify) 28d. DESCRIBE NOW IN.	JURY OCCURED				
	2 Accident Investigation 3 Suicide a Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)							
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Dn the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner as stated.							
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE		ak	29c. LICENSE NU	S71	P 3	Month, Day, Year)	
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGN		,					



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after deat y the fun noval. cal exar	Щ	23. PART I. Enter the d	reae or
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TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within clours after death. Page 6 may be retained by the hospital or attending physician. RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	D BY PHYSICIAN: MEDICAL CERTIFICATION		distering irry
require sen sig of Hex	ME	ANEURY	
I: The law cate has b state Dept.	ICIAN	DID TOBACCO U 25. WAS CASE REFERRED T EXAMINER?	
E E E	TED BY PHYS	2 Accident 3 Suicide 6	Pending Investigation Could not be determined
HOSPITAL OR ATT FUNERAL DIRECTE WITHIN 72 hours at TANT: If item 21	MPLETE	cont only	IFYING PNYS
TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at	BE COMPL	29b. SIGNATURE AND TITLE	_ 1
IM & G	TO	07.00	F PERSON WA

95 07741 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH FRANCIS XAVIER BURNS. FEB.25 1995 7:00PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 6. BIRTNPLACE (State or Foreign MATE DAYS HOURS YRS. 579-10-1171 WASHINGTON. 1921 Da. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN TOR FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK SIDENCE OF DECEDENT STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? D FREDERICK NEW MARKET STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 0609 HIGH BEACH CT. 21774 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO ARITAL STATUS 14. RACE — American Indian, Black, White, atc. Never Married 2 Married IF YES DIVE WAR OR DATES TT WILDOWS MATT BILLIA WHITE 16a. DECEDENT'S USUAL OCCUPATION

work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 BUSINESS OWNER COMPUTER SOFTWARE ATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) OHN THOMAS BURNS HELEN RYAN INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ILEEN E. BURNS 10609 HIGH BEACH CT.NEW MARKET 21774 METHOD OF DISPOSITION BURIAL Burla! 2 Cremation 3 Removal from Donatton 5 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of ST. PETER'S CEMETERY 2/28 LIBERTYTOWN, MD IGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS LIBERTYTOWN, MD PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory streat, shock, or heart fellure. List only one cause on each line. Approximate Interval Between MEDIATE CAUSE (Fine) **Onset and Death** esse or condition ATHEROSCUEGROTIC 18 YRS CARDIOVASCULAR DUE TO (OR AS A CONSEQUENCE OF) quentially liet conditione, DUE TO (OR AS A CONSEQUENCE OF) ny, lesding to immediate JSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): Initisted events ulting in deeth) LAST IT II. Other eignificent conditione contributing to deeth but not reculting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? ATRIAL FIBRILLATION, ABDOMWA1 AORTIC t TYES 2 NO OF DEATHS ANEURYSM t TYES 2 NO oid tobacco use contribute to cause of death yes 🗌 no 🗌 uncertain 🖬 WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 | Nursing Name 5 | Residence 6 | Other (Specify) TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be Nomicide CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and menner as stated. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

AME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) DUNBUSIN 915 TILLHOUSE \$ 203 FREDERICK 32. REGISTRAR'S SIGNATURE

Julia Davidson Redall

31. DATE FILED (Month, Day, Year)

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29d. DATE SIGNED (Month, Day, Year)

particular in the gradient province of the following the contract of the contr and the second of the second o DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DALLIMONE, MANIEANE	nours after death. Page 6 may be retained by the hos	filled in by the funeral director, page 5 should be detached on, or removal.	he medical examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the filled within 72 hours after death with the State Devt. of Health and Mental Hydrene prior to burial. cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,

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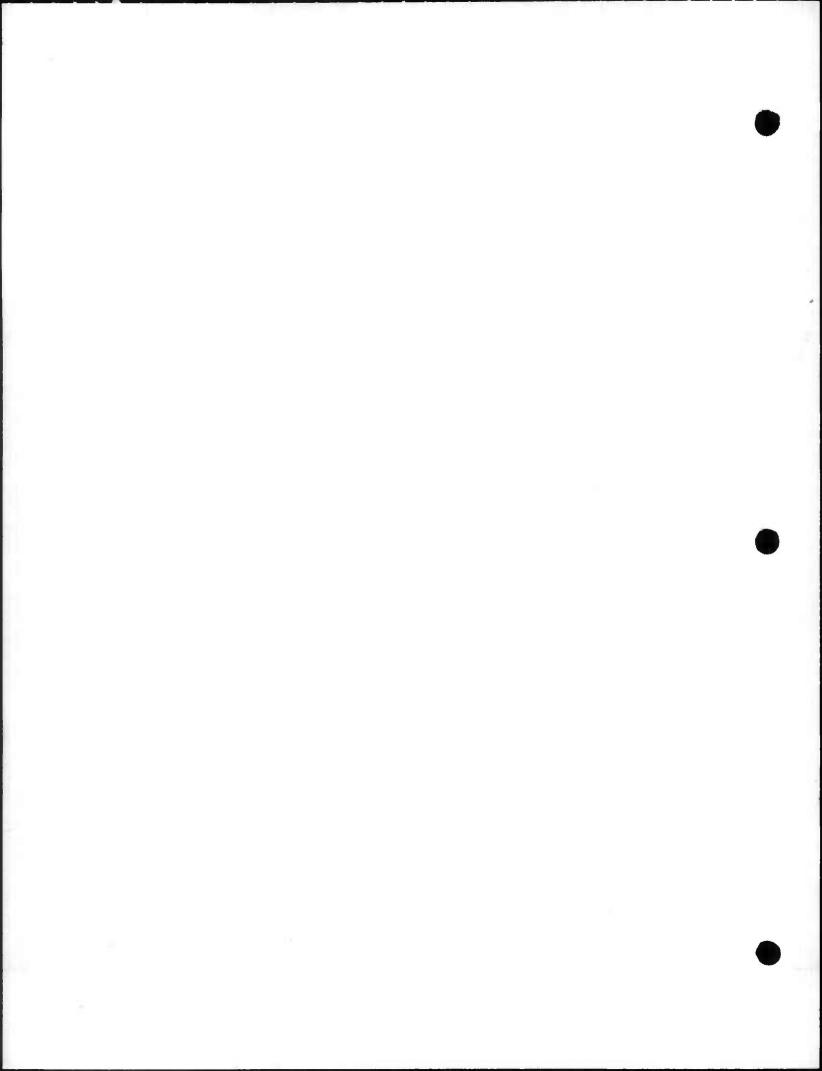
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	REGISTRAR CERT	PARTMENT OF HEALTH AND MENTAL HYGIENE TIFICATE OF DEATH REG. NO.									
2000		ONLIN 2. DATE OF DEATH PAY 1995 0500 M									
	173 07 7277	rs. MONTHS DAYS HOURS MIN. (Mogth, Dey, Hear) 1 County.									
TOR	99. FACILITY NAME (If not institution, give street end number) 400 15TH STREET RESIDENCE OF DECEDENT	9b. CITY, TOWN OR LOCATION OF DEATH OCEAN CITY BC. COUNTY OF DEATH WORCESTER									
DIRECTOR		OCEAN CITY OCEAN CITY 10d. INSIDE CITY LIMITS? 1 KV YES 2 NO									
FUNERAL	100. STREET AND NUMBER 400 15TH STREET	101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA									
ğ	11. MARITAL STATUS 1	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Ricen, stc.) 1 VES 2 NO Specify: WHITE									
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O BE		AILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 4 Donetton 5 Other (Specify) CREMATORY 2-23 SALISBURY											
	21. SIGNATURE OF PUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLI										
	23. PART 1. Enter the diseases, or complicatione that caused the deeth. shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONDITION	Julmonary Anest;									
NON	Sequentisity list conditions, if any, leeding to immediate b. Due to (OR AS A CONSEQUENCE OF):										
HILICATION	cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST d.	ICE OF):									
AN: MEDICAL CE	PART II. Other significant contributing to death but for resulting in the underlying cause given in Part II. 24s WAS AN AUTOPSY PHONOS MAILABLE PROFIT TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check piny gire)										
HTSICIAN:	EXAMINER? 1 □ YEB 2 NO 1 Inpetient 2 □ ER/Outpatient 3 □ DO	OA 4 Nursing Home 5 Residence 6 Other (Specify)									
10	1 Natural 5 Pending (Month. Day, Year) 2 Academ	M 1 YES 2 NO									
COMPLEIED	4 Homicide detayrifined booking, etc. (Specify)	City or Resett, Status									
CMPL	ana)	occurred at the time, data end place, and dua to the cause(e) end menner as stated. Itigation, in my opinion, death occured at the time, data end place, end dua to the ceuse(s) and menner as stated.									
H H	296. SIGNATURE AND TITLE OF CERTIFIER.	mo 29c. Heense Number 29d. Date Signed Month, Day, Bar)									
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David M. Federly, M.D., Lexington Park, Maryland										

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BALTIMORE, MARYLAND 21215-0020	INSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. It is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should it has been and Mental Horizon price and it is burial companion or removal.	s medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trains the flux within 72 hours after death with the State float or Health and Mental Horison prior to burial-trains	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest) Diamond	4-16-6-ER	_ C	laytor	1	2. DATE OF DEATH DO	YEAR OF THE STATE	3. TIME OF DEATH		
		SEX 6. AGE (In y		NDER 1 YEAR	HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 8. BIRTHPLACE (State or Fo. Country)				
S.	90. FACILITY NAME (If not institution, give street Sinai Hospital of			CITY, TOWN C	R LOCATION OF DI					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCAT	ION			10d, INSIDE CITY		
	Maryland Baltim	ore City	Ва		ce City		LIMITS? 1 X YES 2 NO			
VERA	2919 Rosalinda Aver	nue		1	21215		WHAT COUNTRY?			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	P NO ⊠	13, WAS DEC II yee, spe 1 YES	cify Cuben, Mexice	NIC ORIGIN? (Specify Yearin, Puerto Rican, etc.)	Blac	E — American Indien, ik, White, etc.		
COMPLETED	15. DECEDENT'S EDUCATII (Specify only highest grade com Elementary/Secondary (0-12) Co	ON 186 pleted) 186 oflege (1-4 or 5+)	e. DECEDENT'S USUA (Give kind of work of life. Do NOT use retir	one during mos	N at of working	16b. KIND OF BUS	SINESS/INDUSTRY			
	17. FATHER'S NAME (First, Middle, Last)				16. MOTNER'S NA	ME (First, Middle, Maiden Pamela				
O BE	Anthony Lamon 190. INFORMANT'S NAME (Type/Print)	nt Clayton	19b. MAILING ADD	RESS (Street a	nd Number or Rural	Poute Nember, City or Town	LER n, State, Zip Code)			
_	B.C.									
	1 Burtel 2 Cremetion 3 Removal 4 Donation 8 Other (Specify)		ACE AND DATE OF DIS ry, crematory or other pl	ace)	1-9		BAM'S	own, State		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	HOSPITAL	-	22! NAME AN	DADDRESS OF FA	CILITY 1. BELVE	EDENE V	45		
EHILICALION	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
MEDICAL C	PART II. Other algorificant conditions co	entributing to death but n	csuse given in	PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINE AMILABLE PRIOR TO COMPLETION OF CALL OF DEATH? 1 YES 2 NO						
SICIAN:	DID TOBACCO USE CONTRIBU		DEATH YES T		UNCERTAIN	10				
2101	1 YES 2 DAG 1	OSPITAL: Mipatient 2 - ER/Outpatier	ОТ	HER:	5 - Residence	8 Other (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU WOF 1 Y	HC?	2º4 DESCRIBE NOW IN				
בובה פ	3 Suicide 8 Could not be 4 Homicide determined	2 Accident 3 Suicide 8 Could not be building set: (Specify) / At home, ferm, street, factory, office building set: (Specify)								
CIMILE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN DEPTHY ONE) 2 MEDICAL EXAMINER: On					to the cause(e) end men) and manner se stated.		
2 2 2	296. SIGNATURE AND TITLE OF CERTIFIER	wa my)		29c. LICENSE NUN	IBER	29d. DATE SIGNED	Month, Daf, Year)		
	30. NAME AND ADDRESS OF PERSON WHO GO	WA PLETED CAUSE OF BRATH	TEM W7] (Type, Print)				1	11/		
	31. DATE FILED MOVEN, Any, Yang	32, REGISTRAR'S STONATUR	Jali de	rilen R	rlath					



hours after death. Page 6 may be retained by the hospital or attending physician. In the funeral director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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Item

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

The law requires that the death certificate be executed within OR ATTENDING PHYSICIAN: TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: If If

FOR STATE REGISTRAR 10a. STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 02 3. TIME OF DEATH YEAR KATHERINE STARR COBLENTZ 28 95 9:15 Α 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) ?. DATE OF BIRTH (Month, Day, Year) April 1, 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 X F April Maryland 214-10-4641 85 YRS. 1909 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Milestone Garden Apts., Apt. 3-H Williamsport Washington RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Williamsport 1 YES 2XXNO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Milestone Garden Apts., Apt. 3-H 21795 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Ricen, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married Specify White 1 YES 2 NO Specify: 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Executive Secretary Power Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Thomas Starr Emma Louise Kolb 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne C. Gruber 10821 Archer Lane, Williamsport, Maryland 21795 20a. METHOD OF DISPOSITION
1 □ Burial 2 文 Cremation 3 □ Ramoval from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Smithsburg Crematory 03/01/95 Smithsburg, Maryland 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home Douglas A. Fiery 1331 Eastern Blvd. North, Hagerstown, MD 23. PART i. Enter the diseasea, pr compiletions that saused the peeth. Do not enter the mode of dying, such as cardiac or reepiratory arrest, Approximate ehock, or heart fallure. List priv pne cause pn each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death diseese or condition resulting in death) Chrome Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART ii. Other algnificent conditione contributing to deeth but not reculting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 THO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending 1 YES 2 NO Investigation 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide detarmined 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the beels camination and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and mannar as stated. 29b. SGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print MID 31. DATE FILED (Month, Day, Year, 32. REGISTRAR'S SIGNATURE 2 1995



FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last) Elsie May CARROLL		2. DATE OF DEATH DAY
4 COCIAL CECULOTY AND CO		

		1. DECEDENT'S NAME (First	Miridle Leet									T		·		
		Elsie May C		4								MONTH			YEAR	. TIME OF DEATH
		4. SOCIAL SECURITY NUME		last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					Februa	-	2 19	195	0917A M			
				5. SEX	127 227 2	yrs. last birti	MO		YEAR DAYS	HOURS	MIN.	7. DATE 0 (Month,	Day, Year)		8. BIRTHPL Country)	LACE (State or Foreign
9		112-03-9887D 1 1 M 2 (S) = 90 90. FACILITY NAME (If not institution, give street and number)					YRS.						2, 190	4	Cana	.da
pinous	~						96	CITY, T	OWN	OR LOCAT	ON OF D	EATH		9c. COU	ITY OF DEA	TH
2, 3	DIRECTOR	Washington		Hospita	1				Ная	gerst	own			Wa	shing	ton
-,	[I	RESIDENCE OF DEC	10b, COUNT	ν		40	Dc. CITY, TO	WAL OR	1.004	TION						
Page	표	Maryland		hington		1.0										Od. INSIDE CITY LIMITS?
permit. Pages		10e. STREET AND NUMBER		mington			Hagerstown 101. ZIP CODE								YES 2 NO	
	FUNERAL	34 N. Locus		0.4					101					10g. CITI		AT COUNTRY?
an. trans	Ä		L SLIE								21740					
020 physician. burlal-transit	F	11. MARITAL STATUS 1 Never Married 2	Merried	12. WAS DECEDEN	YES	2 K NO	•	13. W/	S DEC	CENDENT (OF HISPAR	NIC ORIGIN?	(Specify Yealcan, etc.)	or No—	14. RACE -	- American Indian, White, etc.
00 pd at a pd o	B	3 X Widowed 4 Divo		IF YES, GIVE Y	MAR OR DAT	TES				2 🔯 NO			, , , , ,		Specify:	
21215-0020 al or attending physician for use as the bunal-tra		15. DEC	EDENT'S EDU	CATION	I N	16a. DECEDE	ENT'S HEH	I	IDATI	011		Lon		1		ite
or after	ETED	(Specify ant	y highest grade	completed)		(Give kil	ind of work NOT use ret	done dur	ring mo	ost of working	ng	166.1	KIND OF BUS			
D 2	2	Elementary/Secondary (6)-12)	College (1-4 or 5	+)							.	hysic	tout.		
A NI he hos detache	COMPL	17. FATHER'S NAME (First, M	liddle (aat)			nurse							ıce			
by the hospital or be detached for un at once.										100			iddle, Maiden S			
IARYLAND stained by the hospit should be detached titfled at once.	BE	Edward McGr				_	Jane Elizabeth Britton									
MARY retained to 5 should	2	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie May Carroll (pre-arranged) 34 N. Locust St., Hagerstow										Code)	21740			
may be		(pre-arranged) 34										34 N.Locust St., Hagerstown, Md.				
e 6 may ector, p		20a. METHOD OF DISPOSITION 1 Burlel 2 X Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20c. LOCATION — City or											City or Town	, State		
M direct		21. SIGNATURE OF SUNERAL SERVICE LICENSEE Commelency, cremetory or other place Commelency Crematory Crema												ryland		
E a fu		21. SIGNATURE OF EUNERA	L SERVICE LIC	CENSEE	*		/	22. NA M T	ME AN	OH F	55 OF FA	CILITY CAL HO				
BALTIMORE, MARYLAND nous after death. Page 6 may be retained by the hospit of in by the funeral director, page 5 should be detached or removal. medical examiner must be notified at once.		SCA	al	1811	nn	uch								orst	arm M.	d.21740
B. nours after d in by the or removal		23. PART i. Enter tha di	Iseases, Dr	complications the	at caused t	the daath.	Do npt	entar th	a mo	da of dy	ing. suc	h aa cardii	ac or reanir	atory arm	out tri	Approximate
nouns or n	1	shock, or he IMMEDIATE CAUSE (Fin	eart tellure.	List only one ceu	use on eac	ch line.								,	-	Interval Between
y filled atton, or		disease or condition	101		20 4 0		P	uln		~	۸	wholi				Onset and Death
of within and within and on pietely fill and it cremation, the event, the	l	resulting in death)		a	(OR AS A C	CONSEQUEN	ICE OFI:					- Herry	2-			to mix
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	\§	cause. Enter UNDERLY	NG													
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b, P.O. leath certificant attending mtal Hygier Y. or oth	7	resulting in death) LAS	T .	d.												
ORDS, P.O. that the death certificated by the attending poth and Mental Hygienn any Injury, or other	- 1	DARW II Out I III														
RECORDS, requires that the dear een signed by the att of Health and Menta shows any Injury.	MEDICAL	PART II. Other algnifice	nt condition	a contributing to	death but	t not result	iting in th	e unde	erlying	g cause (given in	Part I.	24a. WAS AN A PERFORM			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
Signed by Health any BWS any	8	Anteno no	enotice.	Cardie	man		シシ	Ren	\				1 YES 2	NO	C	OMPLETION OF CAUSE F DEATH?
RECC requires een signe of Health	M	Cagarlia	Hean	ur Fail	m											YES 2 -NO
~ 0 ~	ä	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH	YES [UNC	ERTAIN	V E			1	
VITAL AN: The law lificate has state Dep	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26	3. PLACE OF			y one)							
VITA	1S	1 TYES 2 A-NO		1 Inpatient 2	3-ER/Outpati	lent 3 🗆 D		HER:	g Hom	e 5 🗆 Re	sidence	8 Other	(Specify)			
OF PHYSIC This ce with th	E	27. MANNER OF DEATH		26a. DATE OF (Month, D		26t	b. TIME OF	28		URY AT		28d. DESC	RIBE HOW IN	JURY OCC	URED	
	B		Pending Investigation					М		YES 2] NO					
SION TENDING THE After the death The After the	8		Could not be	26a. PLACE O building,	F INJURY —	- At home, fo	arm, streel	, factory	, office	•		26f. LOCAT	ION (Street an Town, State)	d Number	or Rural Rout	te Number,
OR ATTEND DIRECTOR: / hours after item 28 Is		4 Homicide	determined									Oity or	iown, otato)			
OR AT DIRECT DIRECT Hours a ltem 2	2	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the beat of	my knowled	dga, death o	occurred at	the time	, data	and place.	and due	to the cause	e(a) and mann	or as state	d	
THE SET OF THE SET OF									nd manner ee stated.							
THE BE	BE			LET MD							(g c		- 1			onth, Day, Year)
6 6 3 ₹	2	30. NAME AND ADDRESS OF	PERSON WHI	O COMPLETED CALL	SE OF DEAT	H /ITEM 27	(Time Delet	1)			, 0	` [J	2 cn ((4.17)
		VAS NOV - I	シムてて						MA	LER	2-701	ww	Mp 2	(24	6	
		FEB 2 3 1995	Har) Sale	32. REGISTRA	R'S SIGNATI	URE										

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIEN						
ij	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	Virai	nia C. Com	noton			February 18 1995 7P						
i	4. SOCIAL SECURITY NUMBER		'In yrs. last birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. F	BIRTHPLACE (State or Foreign				
	216-46-4415 90. FACILITY NAME (If not institution, give		7 YRS.	NTHS DAYS	HOURS MIN.	Dec 27 18	27 1897 Virginia					
œ	Ginger Cove Heal					AIH	9c. COUNTY					
DIRECTOR	RESIDENCE OF DECEDENT	tir Care Cente		Annap	0115		Anne Arundel					
RE	10e. STATE 10b. COUNT		10c. CITY, TO	OWN OR LOCAT	ION		10d. INSIDE CITY LIMITS?					
		e Arundel		Annar	olis			1 TES 2 NO				
3AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
FUNERAL	3208 River Cres				2140			ed States				
5	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2XX10			IIC ORIGIN? (Specify Year, Puerto Ricen, etc.)		RACE — American Indien, Black, White, etc.				
B≼	Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 🗆 YES	2 XNO Specify	r		Specify: White				
	15. DECEDENT'S EDI	UCATION	1Se. DECEDENT'S USL	IAL OCCUPATION	ON .	16b. KIND OF BU	SINESS/INDUSTI	RY				
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4 or 5 +)	(Give kind of work life. Do NOT use rel	done during mo tired.)	st of working							
린	10		Homer	maker			Home					
S I	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle, Malden	Surname)					
BE (Edgar B. Calver	t			Anr	ne Stehlin						
6	19a. INFORMANT'S NAME (Type/Print)					loute Number, City or Tow						
-	Virginia C. Hal	<u>e</u>	488 Fe	rry Po	int Rd .	Annapolis,	Maryla	and 21403				
	20a. METHOD OF DISPOSITION 1 Date 20c. LOCATION — City or Town, Sta											
	4 Donation 5 Other (Specify)		. Lincoin									
1	V C HILL							Funeral Home				
	1 DAK SE	MANNY.						apolis, MD				
Ī	23. PART i. Enter the diseases, or shock, or heert fallure.	complications that caused. List only one cause on ea	I the death. Do not a	enter the mo	da of dying, suct	ss cerdiac or respi	iratory srrest,	Approximate interval Between				
	iMMEDIATE CAUSE (Final disease or condition	CHE						Onsat and Death				
]	resulting in desth)	a										
			DUE TO (OR AS A CONSEQUENCE OF):									
ERTIFICATION	Sequentially list conditions,	b	CONSEQUENCE OF):									
¥	if any, leading to immediate cause. Enter UNDERLYING											
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):									
	resulting in death) LAST	d										
C	PART if. Other significent condition	ns contributing to deeth b	ut not resulting in th	ne underlying	ceuse given in l	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS				
N N				,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE				
MEDIC						1 YES 2	N NO	OF DEATH?				
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	ПИОГ	UNCERTAIN	1/12		1 TYES 2 NO				
Ž	25. WAS CASE REFERRED TO MEDICAL	T	26. PLACE OF DEATH (C		OTTOLKIAII	781						
PHYSICIAN:	EXAMINER? 1 YES 2 XNO	HOSPITAL: 1 Inpatient 2 ER/Outp	etlent 3 DOA	HER: Nursing Home	5 - Reeldence	S Other (Specify)						
훈	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		JRY AT	28d. DESCRIBE HOW I	NJURY OCCURE	D				
BY	1 Natural 5 Pending 2 Accident Investigation	(1334, 13), 134		M 1 🗆 Y								
ED	3 Suicide S Could not be	28e. PLACE OF INJURY buffding, etc. (Spec	— At home, term, street	t, tectory, office		281. LOCATION (Street & City or Town, State)		ural Route Number,				
	4 Homicide detarmined											
COMPLET		SICIAN: To the best of my knowl	edge, death occurred at	the time, date	end place, and due	to the cause(e) end mer	nner se stated.					
ś I	one) 2 MEDICAL EXAMINI	ER: On the beals of examination	end/or investigation, in	my opinion, de	eath occured at the	time, data and place, an	d due to the cau	ree(a) and manner se stated.				
296. SIGNATURE AND TITLE DI CERTIFIER 29c. LICENSE NUMBER								NED (Month, Day, Year)				
2	Fores	, Jus			D38158		▶Febru	uary 22, 1995				
-	30. NAME AND ADDRESS OF PERSON WE				!	VD 04404 (440 00	7 0014				
	Lisa A. DiMarzio			ve Ann	apolis,	VD 21401 (410-26	7-9211)				
	31. DATE EBMO 2. 8 1995	#2. HE STRAT'S SIGN	ardall									
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH RICHARD CARLTON CAMPBELL 2 SR 1999 5:15 pm 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 5. SEX 7. DATE OF BIRTH (Month, Day, Yea 6. AGE (In vrs. last birthday) IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 27 1 M 2 F 12 1995 Haymarket, Va. 721-03-5819 should 9a, FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 209 Pages 1, 2, 3 Thomas Av. Frederick, Frederick RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick XX YES 2 NO permit. FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 209 Thomas Av. by the hospital or attending physician. be detached for use as the burial-transit 21701 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or NeI1 yes, specify Cuben, Mexican, Puerto Ricen, etc.)
1 YES 2 X YO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indien, Bleck, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried Specify: White BY 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S LISUAL OCCUPATION 16h, KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) ring most of working (Give kind of work done life. Do NOT use retired.) Fairfax County Elementary/Secondary (0-12) College (1-4 or 5+) 8th Highway Dept. Maintance 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) Joseph Washington Campbell te Sarah Elizabeth Leonard BE funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Shirley Keener 18 Turner Dr. Stafford, Va. 22554 be 20a, METHOD OF DISPOSITION
| Source | 2 | Cremation | 3 | Removal from Stata | 4 | Donation | 5 | Other (Specify) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Hitt Family Cemetery 3/1/95 Amissville, Va. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DLASIUS-BAKER FUNERAL HOME

9320 West ST. Manage Co.

23. PART I. Enter the disesses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pnly one cause on each line. n by the removal. medicai filled in by Approximata Interval Between 0 IMMEDIATE CAUSE (Final Onset and Death cremation, the disesse pr condition MALIGNANT LARGE CELL LYMPHONA 2 YEARS npletely resulting in deeth) event, DUE TO (OR AS A CONSEQUENCE OF): burial, other traumatic CERTIFICATION and Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease or injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in desth) LAST 0 the atten Mental A injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL by AVAILABLE PRIOR TO any signed the COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? shows a 1 TES 2 NO t of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO 154 PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATN (Check only one) item certificate to the State HOSPITAL 1 - YES 25 NO OTHER 1 Inpetiant 2 ER/Outpetient 3 DOA 0 28e. DATE OF INJURY (Month, Day, Year) 27, MANNER OF DEATN 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, this with 1 D4 Natural 5 Pending Investigation 1 YES 2 NO ВУ death death 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 6 Could not be DIRECTOR: 28 4 Homicide item 29a. CERTIFIER 1/54 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es ateted. FUNERAL I = 2 MEDICAL EXAMINER: On the besis of exemination TO THE HOSPITE
TO THE FUNERA
De filed within 72
IMPORTANT: 13 and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER B cons D31761 126/95 0 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

BRIAN M. O'CONNOR MD 501 W. SEVENTY ST.

32. RESISTION'S SIGNATURE

31. DATE FILED (Month, Day, Year)
MAR Q 9 1995

FREDERICK MD

RICHARD CARLTON CAMPBELL , SR. 2 26 1995 5:15 pm 12 27 1995Haymarket, Va. 721-03-5819 XX 75 209 Thomas Av. Frederick, Frederick Maryland Frederick XX Frederick 209 Thomas Av. 21701 U.S.A. XX XX White Fairfax County Highway Dept. 8th Maintance Joseph Washington Campbell Sarah Elizabeth Leonard

Shirley Keener

XX

18 Turner Br. Stafford, Va. 22554

Hitt Family Cemetery 2/1/95 Amissville, Va.

BLASIUS-BAKER FUNERAL HOME 9320 West ST. Manassas, Va. 22110

10.00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	4. SOCIAL SEC
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	C	ERTIF	ICATE	OF	DEATH	R	EG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR MONTH DAY YEAR												
	Ruth D. Costen							-	_3:45 p ™				
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. Is	st birthday)	IF UNDER 1	YEAR	IF UNDER 24 HRS.	7. DATE OF E	oruary 26, 1995			IPLACE (State or Foreign		
	214-10-6093 1 n 2 x		YRS.	MONTHS 0	DAYS	HOURS MIN.	Mar .	30, 1	899	Countr	Md.		
	9e. FACILITY NAME (If not institution, give street end number)				R LOCATION OF DI	EATH			JNTY OF D			
DIRECTOR	Deer's Head Center			S	ali	sbury			Ma	aryla	nd-Wicomico		
ᄗ	RESIDENCE OF DECEDENT												
E			IOC. CIT								10d, INSIDE CITY LIMITS?		
	Md. Wicomico		Sa1i							1 XYES 2 NO			
FUNERAL	1307 Taney Avenue			107.	21801			VHAT COUNTRY?					
5		DENT EVER IN U.S. A	RMED	13. WA	S DEC	ENDENT OF HISPAI	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indien,		
ВУ		VE WAR OR DATES	NO			2 XNO Specif		ı, etc.)		Speci	White		
9	15, DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. D	ECEDENT'S	USUAL OCC	UPATIO	N at of working	16b. KIN	D OF BUS	BINESS/IN	DUSTRY			
COMPLETED	Elementary/Secondary (0-12) College (1-4	or 5 +)	(Give kind of work done during most of working life. Do NOT use retired.) rsonnel Director DP&L										
OM	17. FATHER'S NAME (First, Middle, Last)	10.	. 50111			18. MOTNER'S NA							
BE C	Severn Dawson						adie		man				
TO B	19m. INFORMANT'S NAME (Type/Print)	-11	9b. MAILING	ADDRESS (S	Street e	nd Number or Rural	Route Number, C						
F	Polly Dawson		130	7 Tan	ney	Avenue	e, Sal	isb	ury	ry,Md. 21801			
	20e. METNOD OF DISPOSITION 1 № Burlel 2 □ Cremation 3 □ Removal Irom State			OF DISPOSITI	ON (Na	me of	DATE						
	A Donation 5 Other (Specify) Cemejory, Crematory or Other place) Wico. Mem. Park Salisbury, Mc												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		D _	22. NA	ME AN	D ADDRESS OF FA	CILITY						
	* Suald C X	Wune)	8								bury, md.		
	23. FART I. Enter the diseasea, or complications that caused tha death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one cause on each line. iMMEDIATE CAUSE (Final												
- 1	IMMEDIATE CAUSE (Final disease or condition												
-	resulting in death) a. Congestive heart failure-recurrent												
_	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. Possible pneumonitis Due to (or AS A consequence of):												
S	CAUSE (Disagraphy Injury CAUSE (Disagraphy Injury CAUSE (Disagraphy Injury CAUSE)												
E	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):								15 years			
5	d				_	-							
اب	PART II. Other significant conditions contributing	g to death but not	rasulting	in the unde	eriying	cause givan in	Part I. 24e	. WAS AN		24b	. WERE AUTOPSY FINDINGS		
DICAL	Alzheimer's diseas	2					1.5	PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE		
							_ ' '		M NO		OF DEATH?		
PHYSICIAN: ME													
¥.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PL	ACE OF DEATH (Ch	eck only one)			_			
S	HOSFITAL	2 ER/Outpatient	3 🗆 DOA	OTHER:	g Home	5 🗆 Residence	6 Other (Sp	ecify)					
	(Mor	E OF INJURY th, Day, Year)	28b. TIM		8c. INJI		28d. DESCRIE		JURY OC	CCURED			
BY	1 Natural 5 Pending 2 Accident Investigation					ES 2 NO					1		
60	3 Suicide 8 Could not be 28e. PLA	CE OF INJURY — At h	ome, larm,	etreet, lactory	y, office		281, LOCATIO City or To	N (Street a	nd Numbe	er or Rural F	loute Number,		
						_							
릴	29e. CERTIFIER (Check only one)												
COMPLET	2 MEDICAL EXAMINER: On the basis	of axamination end/or	Investigation	on, in my opir	nlon, de	eath occured at the	time, date end	place, and	d due to t	the cause(e) end manner ae stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI	MBER		29d. DA	TE SIGNED	(Month, Day, Year)		
TO B	Vugen & Wula	y MDC				B 3390	5)	2/2	7/95		
F	30. NAME AND ODRESS OF PERSON WHO COMPLETED		, , , , ,										
	Virginia A. Dulany, M.	D., CMD	P.O.	Box 2	2018	Salisb	ury, M	1. 2	1802	-2018	3		
	31. DATE FILED (Month, Day, Year) 32 REGIS	dhudior ha	1.11										
- 1	FEB 2 8 1995 Julia	Water Make	out of								1		

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BALIIN	IE HDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pag	PERSONAL PROPERTY. Advantage and product the state of the
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DIVISION OF VITAL RECORDS, P.O. BOA 60/00	8	GIC
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		1 - STATE REGISTRAR		STATE OF I	MARYLA	AND /	DEPAR	TMENT	OF H	HEALTH	AND I	MENT					
		1. DECEDENT'S NAME (First,	, Middle, Lest)		CERTIFICATE OF DEATH								REG. NO.			3. TIME OF DEATH	
		Janice		н.			(211	in	<		MON	ITH DA		YEAR		
		4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (//	in yrs. lea	t birthday)	IF UNDER 1		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTH		PLACE (State or Foreign	
-		220/32/9328	3	1 □ M 2 🙀 F	58		YRS.	MONTHS DAYS HOURS MIN.		4/2	T /T 936	Mary		yland			
shoul		9e. FACILITY NAME (If not in								ATH	ATH 9c. COUNTY OF DEATH						
5,	힏	PENINSULA		AL MEDIC	AL CI	AL CENTER SALISBURY			RY	WICOM				CO			
Des 1	DIRECTOR	10a. STATE	10b. COUNTY	1				10c. CITY, TOWN OR LOCATION							10d, INSIDE CITY		
æ .≅	5	Delaware	Suss	sex	Millsboro								LIMITS?				
E e	3AL	10e. STREET AND NUMBER			101, ZIP CODE							10g. CIT	IZEN OF W	HAT COUNTRY?			
physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL	R.D. 3 Box	232							1996				USA	1		
pmysician. burial-trar		11. MARITAL STATUS 1 Never Married 2	Married		YES	YES 2XXNO If yes, specify Cuban, Mexican, Pue						n, Puerte		or No-	14. RACE Black	- American Indian, , White, etc.	
2 a	BY	3 Widowed 4 Divo	rced	IF YES, GIVE Y	MAR OR DA	TES		1	_ YES	2 (XNO	Specify	r:			Spech	white	
r attending use as the	8	15. DEC (Specify only	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working							INESS/INC	DUSTRY	WILLE					
0 -	9	Elementary/Secondary (0	+)	Me.	Do NOT u	se retired.)			8								
detached for once.	COMPLET	11 FATHER'S NAME (First AM	iddie (aat)			hot	usew	Lie									
	ЕСС	17. FATHER'S NAME (First, Middle, Lest) Lloyd W. Harrington Doris E. Larmore															
5 should be	BE	19a INFORMANT'S NAME (King Print)											n. State. Zic	State, Zip Code)			
be retailed and a not	임	Elxey J. Collins R.D. 3 Box 232, Millsboro, Del. 19966															
e 6 may be ector, page must be		20a. METHOD OF CISPOSITION 1 © Burfel 2 Cremetton 3 Chemoval from State 4 Donatton 5 Chemoval from State 4 Donatton 5 Chemoval from State 4 Donatton 5 Chemoval from State Millsboro Cemetery 2/19 Millsboro, Del.															
death. Page 6 may be funeral director, page xaminer must be a		4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERAL	(Specify)		M	111	sbor						19 Mil	Lsboı	0, D	el.	
death. Pag tuneral dir l. examiner		21. SIGNATURE OF FUNERAL	L SHVICE LIC	ENSEE						ND ADDRES			Wd.	11-1-		D - 1	
9 70 80		pechan	1	Wal	con)							ome, Mi		-	Del.	
urs in t		23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final															
# 6 # B		IMMEDIATE CAUSE (Fin	al	12	/			r 1	IA								
# 6 E		IMMEDIATE CAUSE (Final disease or condition resulting in death) a. // Lenworkogs CVA: B. days: Onset and Death 8 days: Out to (or as a consequence of): b. metastatu Cemian to brain unlinour 1° 2 mos.															
2 5 m	z																
	CERTIFICATION	If any, leading to immediata															
physician ne prior t	2	Cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):															
attending physician antal Hygiene prior (H	that initiated events resulting in death) LAST															
	CE	DART II Coh a shakilant and ill and a shakilant and a shakilan															
mat the ned by the th and M any inju	AL	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO															
igned igned sealth	MEDICA											1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?		
w requires that it been signed by pt. of Health and 3 shows any it		DID TOBACCO U	SE CONTE	DIRLITE TO CA	LISE OF	DEAT	ru vr	S 🗆 N	о Г	1 UNIC	EDTAIN		1			1 TYES 2 NO	
has by Dept.	SICIAN:	25. WAS CASE REFERRED TO		MBOTE TO CA				H (Check or		UNC	ERTAIN	<u>ч </u>					
certificate h the State d, or Item	SIC	EXAMINER?		10SPITAL:		-		OTHER:		e 5 Re	aldence	8 🗆 Он	er (Specify)				
this certif with the rked, or	РНҮ	27. MANNER OF DEATH		26a. DATE OF (Month, D	INJURY		28b. TIM		8c. INJI	URY AT		_	ESCRIBE HOW IN	JURY OC	CUREO		
After this death with	BY		Pending Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	a), 10a1/			М		RK? /ES 2	NO						
DR: Af			Could not be	28e. PLACE O building,	etc. (Specif	- At hor	ne, farm, e	rtreet, factor	y, office	•		281. LO City	CATION (Street as	nd Number	or Rural Re	oute Number,	
L OR ALTENDING P DIRECTOR: After the hours after death item 28 is man													_				
TAL O	COMPL			CIAN: To the best of													
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 h IMPORTANT: If it	00			R: On the basis of e	xamination	end/or Ir	veetigatio	n, In my opi	nlon, de	eath occur	ed at the	time, dat	e end place, end	due to th	e ceuse(e)	end menner ee stated.	
THE HDSPITAL OR ATTENDING PHYSICIAN: The law requires that the THE FUNEFAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept. of Health and MPORTANT: If I Item 28 is marked, or Item 23 shows any Injun.	BE	296. SIGNATURE AND TITLE	\supset	1	2			29c. LICE	NSE NUM		9			(Month, Day, Year)			
₽ ₽ 2 ≥	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETEO CAUS	SE OF DEA	TH (ITEM	27) (Tuno	Print)								7-95	
		Charles D.	Ste	gman 1	MD	30	1434	1 M	t.Ve	rno	7 R	d.	Prince	255 1	Anne	MD 21853	
12		FEB 2	3 1995	Julia de	Junton.	RANG	lall								,	MD 21853	

 BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BRUCE CLARKE FEBRUAR 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Morith, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 501-14-4006 1 🔀 M 2 🗌 F June 24. Windsor Ontario Canada permit. Pages 1. 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Charlotte Hall Veterans Home Charlotte Hall Charles RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montagmery Rockville 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11414 Ashley Drive ours after death. Page 6 may be retained by the hospital or attending physician. I in by the funeral director, page 5 should be detached for use as the burial-transit 20852 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. It yes, specify Cuban, Mexican, Puerto Rican, etc.)

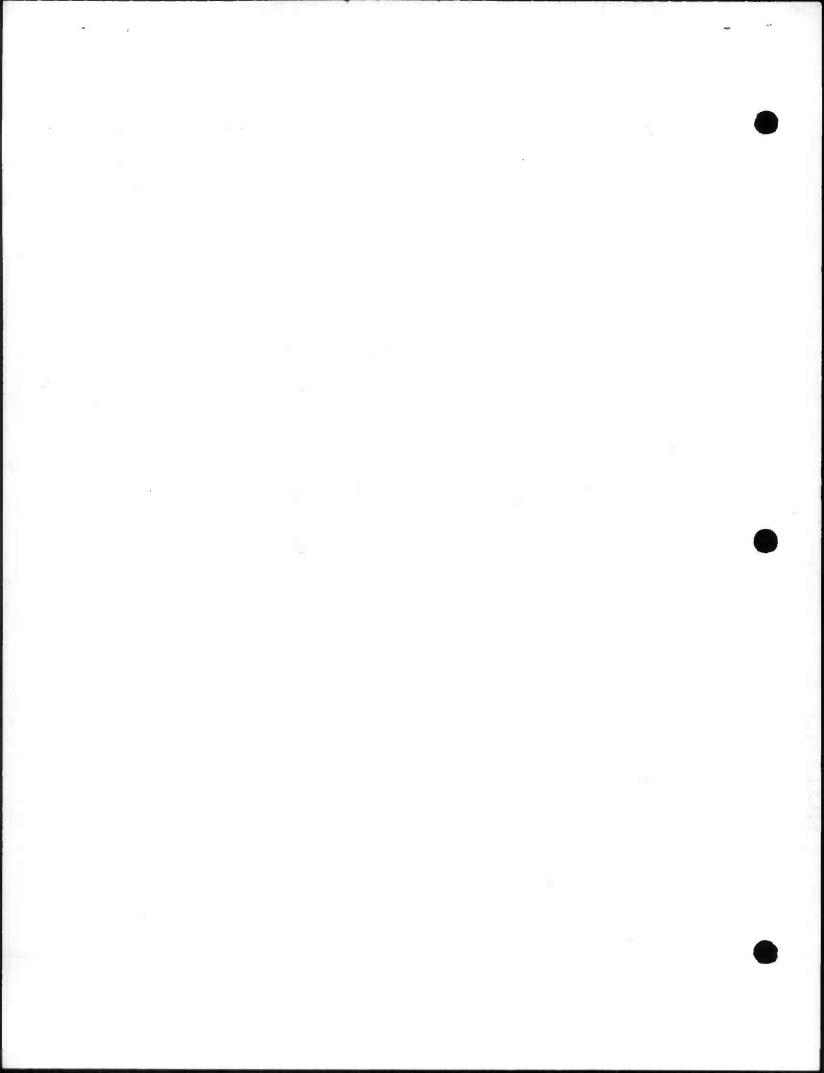
1 YES 2 NO Specify: 1 Never Married 2 Married Specify: B 3 Widowed 4 Divorced WW II & Korean White ETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Senior Engineering Staff Assoc. Applied Physics Lab. Johns Hopkins 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) Robert Clarke Winifred Grace Meyers notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldred B. Clarke 11414 Ashley Drive Rockville, Md. 20852 9 20s. METHOD OF DISPOSITION
1 X Burlat 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must 17. 1995 St. Peters Cemetery 4 Donation 5 Other (Specify) Lewes, Delaware medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Parsell, Atkins & Lodge Funeral Home, Lewes, De. ysician and completely filled in by the prior to bun'al, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, ahock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition event, resulting in death) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other **OUE TO (OR AS A CONSEQUENCE OF)** that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Brain Organic t TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Item certificate h HOSPITAL . OTHER:
Nursing Nome 5 Realdence 8 Other (Specify) 1 YES 2 NO Inpatiant 2 - ER/Outpatient 3 - DOA of the 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCUREO marked, 1. Natural 5 Pending 1 | YES 2 | NO After 2 Acctdent 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, tarm, street, factory, offica building, atc. (Specify) 3 Suicide 100 DIRECTOR: A COMPLETED 4 Homicide 200 determined TO THE HOSPITAL DR AT TO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If Item 2 29a, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 3 -13-95 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print)

120 Hospital Road, Prince Frederick, Md. 20678

22 MEDISTRAN'S SIGNATURE.

Jon Lowenthall

31. DATE FILEO (MORITI, Day, Year)



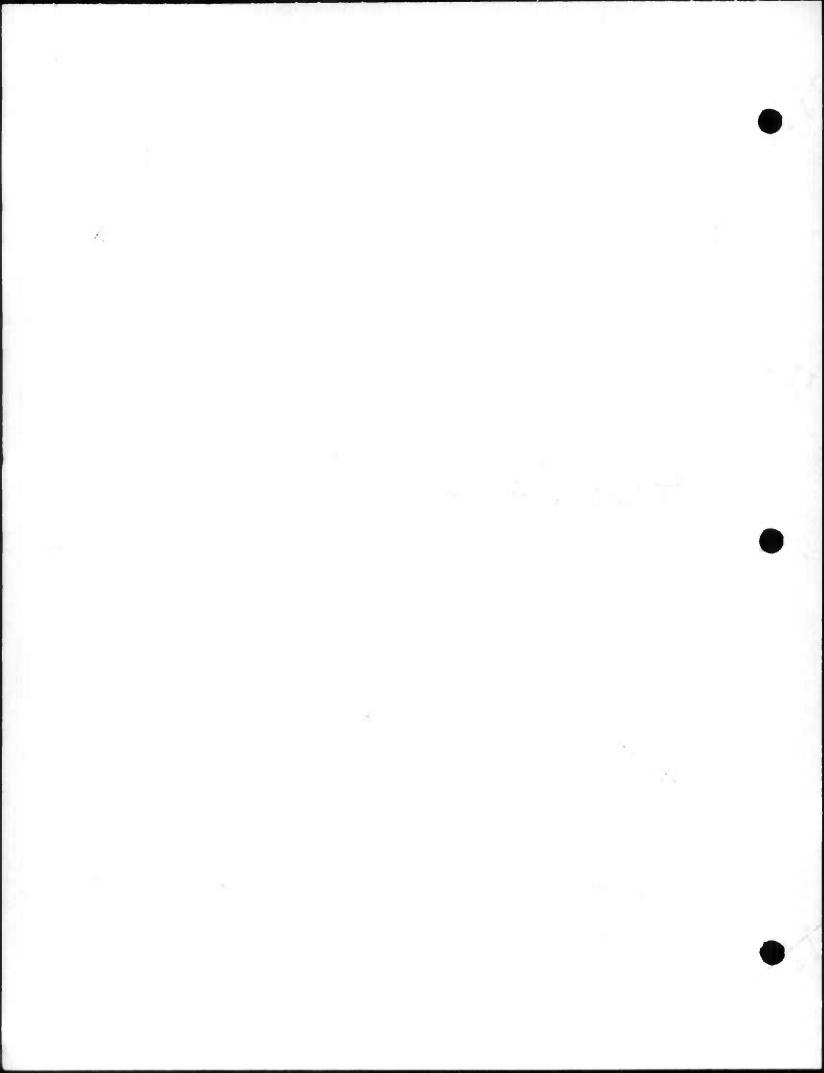
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last) Bette	Jane Church					2. DATE OF DEATH DAY YEAR STIME FEBRUARY 28 1995				
ECTOR	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH		RTHPLACE (State or Foreign		
	216-20-7657	1 □ M 2 XF 67	7 YRS.	MONTHS DAYS	HOURS MIN.	May 1	, 1927 6 1927	Co	ennsylvania		
	9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOWN	OR LOCATION OF D			. COUNTY O			
	750 Warren Drive	>	Annap	Annapolis			Anne Arundel				
OC.					TOWN OR LOCATION				10d. INSIDE CITY		
0	MD Anne Arunde I				Annapolis				1 YES 2 NO		
FUNERAL		101	101. ZIP CODE 21403				F WHAT COUNTRY?				
SNS	750 Warren Driv	12. WAS DECEDENT EVER II	NUS ARMED	12 WMS DEC					States		
	1 Never Married 2 Merried	FORCES? 1 YES	2XLXN0	If yes, sp	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Mexican, Puerto Ricen, atc.)				ACE American Indian, ack, White, etc.		
ЭВУ	XX Widowed 4 Divorced			1,012	1 □ ves 2XXNO specify: Specify: Wh i						
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	JCATION e completed)	(Give kind of v	USUAL OCCUPATION WORK done during mo	done during most of working						
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homen	•			Hame				
MO	17. FATHER'S NAME (First, Middle, Last)		TMIAI	lakei	18. MOTHER'S NA	ME /First Afinded					
BE C	Carl Shanafelt					le A. (
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural						
F	Rodney Q. Church		616 Ra	ando I ph I	Road New	port N	ews, V	irgin	a 23605		
31	20e. METHOD OF DISPOSITION Burlet 2 Cremation 3 Ren		PLACE AND DATE O			OATE	20c. LOCATI	ON — City or	Town, State		
	4 Donation 5 Other (Specify)	CENTRE ()	aryland V						e, Maryland		
1	W. 11	1 1		22. NAME AN	ID ADDRESS OF FA	GLITY John	M. Ta	aylor	Funeral Home		
_	MMINN SI	. Hay /or							polis, MD		
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, about, or heart feliure. Liet only one ceuse on each line. Approximate interval Between Conact and Decider of condition resulting in deeth) a.										
Z	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentielly lilat conditions, if any, leading to immediate cause. Enter UNDERLYING										
FIC	CAUSE (Disease or injury that initieted events	C. DUE TO (OR AS A	CONSEQUENCE OF):							
FRT	reaulting in death) LAST	d									
	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
ICAL	PERFORMED?								AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC						_ 10	YES 2 X	NO	OF DEATH?		
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER?										
IXSI	1 TYES 2 NO	1 Inpetient 2 ER/Outp	atient 3 DOA	OTHER: 4 Nursing Home	Residence	6 Other (Sp	ecify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIME	JRY WO	RK?	28d. DESCRIE	BE HOW INJUR	Y OCCURED			
B	2 Accident Investigation	26a PLACE OF IN HIDY	Al home form of		ES 2 NO						
TED	3 Suicide 4 Could not be determined 6 Could not be determined 6 Could not be determined 6 Could not be building, stc. (Specify) 26e. PLACE OF INJURY — Al home, ferm, street, fectory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number of Rural Ro								I Route Number,		
COMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, end due to the cause(e) and manner ee stated.										
NO.	one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner se stated.										
BE C	198. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)										
2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
	Marshall Salkin,		val Acade		apolis.	Maryla	nd				
	MAR 02 1995 MAR	32, REGISTRAR'S SIGNA									
	111111 02 10001 17	- Inton-Land Day									



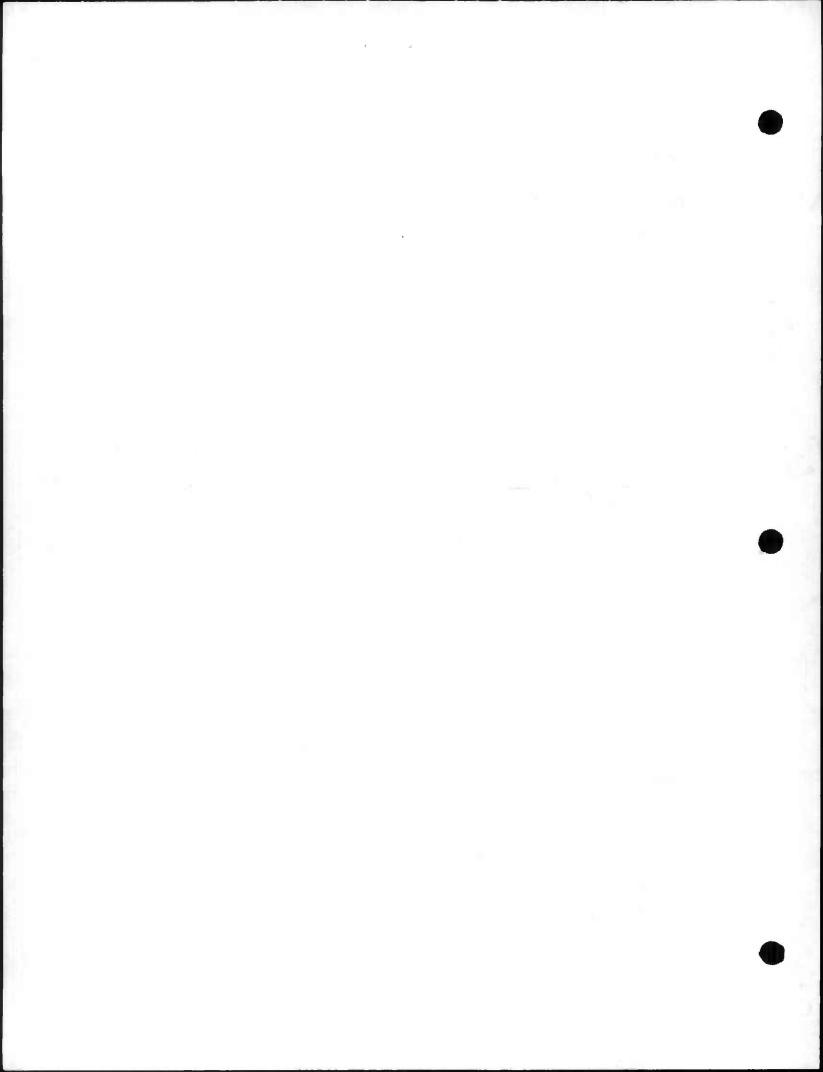
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flar death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR 1 - STATE REGISTRAR	STATE OF M	IARYLAND / DEI CERT	PARTM	ENT OF H	EALTH AND DEATH	MENTAL HYGIEI				
- 8	1. DECEDENT'S NAME (First, Middle, Last)		-				2. DATE OF DEATH			3. TIME OF DEATH	
- 1	Barbara	Costant	ino					DAY	YEAR	6:20 A	
Ŋ	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birth	day) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	March 1,1	995	a RIGTHS	PLACE (State or Foreign	
	578-38-2098	1 M 2 GF		MON	THE DAYS	HOURS MIN.	(Month, Day, Year)		Country,)	
-11	9a. FACILITY NAME (If not institution, give	street and number)	63 "	- ab	CITY TOWAL	P LOCATION OF F	LJune 15,1		Mary INTY OF DE		
DIRECTOR	3220 Captain Dement Drive Waldorf								arles		
E C	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY	
¥	Managara a					LIMITS?					
	Maryland Charles Waldorf									1 YES 2 NO	
FUNERAL	IOS. STREET AND NUMBER				101	ZIP CODE		10g. CITI	IZEN OF W	HAT COUNTRY?	
<u> </u>	3220 Captain De					2060	3	Ur	betin	States	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARMED YES 2 NO		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye	a or No-	14. RACE	- American Indian, White, etc.	
B	1 Never Married 2 Married		AR OR DATES X			2 NO Speci	en, Puerto Ricen, etc.)		Specify		
	3 Widowed 4 Divorced	<u> </u>				XX	•		White		
3	15. DECEDENT'S EDI (Specify only highest grad	UCATION			AL OCCUPATIO		16b. KIND OF BU	SINESS/IND			
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5 +	Illin Do M	or work OT use ret	done during mo ired.)	st of working					
COMPLETED	12										
5	17. FATHER'S NAME (First, Middle, Last)		House	WITE	2	40 1407115010 11	Home				
							AME (First, Middle, Maider				
B	Russell Laffatl	e Brown				Ade M	ary Dodd Route Number, City or Tox				
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAI	LING ADD	PRESS (Street a	nd Number or Rural	Floute Number, City or Tox	vn, State, Zip	Code)		
- 1	Gina M. Costanti	no	3220	Car	otain I	Dement D	r., Waldor	f, Md	1 2060	J3	
	20a, METHOD OF DISPOSITION										
	20e. METHOD OF DISPOSITION 17 Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name March 3, 1955 20c. LOCATION - City or Town, State Clinton, Maryland										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Resurrection Comptery Clinton, Maryland							T 6622			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinon, Md 20735										
	1.5K 7.				OLU AL	exalider	rerry Roa	a, cr	THON!	, Ma 20/35	
	23. PART I. Enter the diseeses, or	complications that	ceused the desth.	Do not e	enter the mo	de of dying, au	ch as cardiec or resp	iratory arr	reat,	Approximate	
	anock, or neert failurs. List only ons cause on sech line.									Interval Between Onest and Dag	
	IMMEDIATE CAUSE (Finel disease or condition										
H	resulting in death) Pancreatic Cancer									2 Years	
		DOE 10 (OR AS A CONSEQUENC	E OF):						l	
5	Sequentially list conditions,										
EHILICATION	If any, leading to immediats										
3	CAUSE (Disease or Injury										
	that initiated events	DUE TO (OR AS A CONSEQUENC	E OF):							
=	resulting in death) LAST										
3											
اي	PART II. Other aignificant condition	na contributing to	death but not recult	ng In th	e underlying	ceuse given in				WERE AUTOPSY FINDING	
MEDICAL	PERFORI							2 200	COMPLETION DF CA		
3							1 □ YES	1		OF DEATH?	
2	DID TOBACCO USE CONT	ICE OF DEATH		1111/1/200-11			1	1 YES 2 XNO			
3		KIDUIE IU CAL				UNCERTAI	иП				
PHISICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
2	1 TYES 2 NO		ER/Outpetient 3 🗆 DO		Nursing Hom	5 Aesidence	8 Other (Specify)				
F	27. MANNER OF DEATH	28a. DATE OF I		TIME OF		JRY AT	28d. DESCRIBE HOW	INJURY OCC	CURED		
	1 Natural 5 Pending Investigation										
è l	2 Calaba	28e. PLACE OF	INJURY — At home, fa	rm, street	, factory, office		281, LOCATION (Street	and Number	or Rural Ro	ute Number	
3	3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								or Hural Houte Number,		
COMPLE	AA. APPATITIES										
<u> </u>	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										
5	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end manner as stated.										
	296. SIGNATURE AND TITLE OF CENTERS	-4				29c. LICENSE NU		_			
# 	14.	1			- 1	D2035				Month, Day, Year)	
, pi	21/M/14 / 7/ V					レムひょう	r.	I IVI	CIT [[1]	1 1997	

MD 8926 Woodyard Road #201, Clinton, Md 20735

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Julia Dawdon Rardall



FOR STATE

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	ERTIF	ICATE OF	DEAT	Ή	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MOUTH ADDRESS OF DEATH MOUTH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOUTH ADDRESS OF DEATH MOU								3. TIME OF DEATH		
1		ving	ton		February 17		95°	15:45 M			
_	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. let	st birthday)		IF UNDER		DATE OF BIRTH (Month, Day, Year)		e. BIRTHP	PLACE (State or Foreign		
	214-32-7036 1-X ^{M 2} -F 95	YRS.	MONTHS DAYS	HOURS	MIN.	EPT. 7, 18	899		LAND		
	9e. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN O	R LOCATIO				NTY OF DE			
9	MEMORIAL HOSPITAL		EASTON TALBOT								
ᇤ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c CIT	Y, TOWN OR LOCAT								
DIRECTOR								1	10d. INSIDE CITY LIMITS?		
اتا	MARYLAND QUEEN ANNE'S 10e. STREET AND NUMBER	W	YE MILI				140 - 017		1 YES 2 NO		
8	134 HOPKINS PLACE			ZIP CODE			log. Cit		HAT COUNTRY?		
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR	MED		2167		ORIGIN? (Specify Yee	or No	USA	- American Indian,		
	1 Never Merried 2 Merried FORCES? 1 YES 2 WI	NO	If yee, spi	elfy Cuban	, Mexicen, F	Puerto Rican, etc.)	Or NO.	Black,	White, etc.		
BY	3 Wildowed 4 Divorced		1 123	2 X NO	зреспу.		- 1	Specify	WHITE		
COMPLETED	15. DECEDENT'S EDUCATION 16e. DE (Specify only highest grade completed) (G	CEDENT'S	USUAL OCCUPATIO	N et of weeking		16b. KIND OF BUS	INESS/INE	DUSTRY			
9		. Do NOT u	se retired.)	at or working	,						
MP	9 -0-	BRO	KER			GI	RAIN				
8	17. FATHER'S NAME (First, Middle, Last)			16. MOTH	ER'S NAME	(First, Middle, Maiden	Sumeme)				
8E	HENRY COVINGTON			LI	LLIA	N ESTELI	ER	EED			
2						te Number, City or Town					
. 1					. , W	AYNESBOI					
		and DATE	of disposition (Nei ther place) OPKINS	me of		DATE 20c. LOC		City or Tow			
	4 Donation 5 Other (Specify) JOHN 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	к. н	22. NAME AN	CEMI	ETER	Y 2-21	WYE	MIL	LS, MD		
	5	FS A		M FU	UNER	AL HOME,	Р.	A.			
	The de president	- 1	200 9	5. HZ	ARRI	SON ST.	. EA	STON	, MD		
	23. PART i. Enter the disease, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate										
ŀ	IMMEDIATE CAUSE (Final Onset and Death										
	reculting in deeth) Chrace Cerphan arrest munte										
Į.	DUE TO (OR AS A CONSEQUENCE OF):										
S	Sequentially list conditions, our TOKOR AS NOONSEQUENCE OF:										
CERTIFICATION	If eny, leading to immediate couse. Enter UNDERLYING										
윤	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEC	DUENCE OF	FIC IV	WU	Inse	earl			179		
E	resulting in deeth) LAST		,						i '		
빙	0										
DICAL	PART II Other eignificent conditions contributing to deeth but not r	esulting	In the underlying	cause gl	ven in Par	rt I. 24a, WAS AN / PERFORI			VERE AUTOPSY FINDINGS		
ă	Corcyunga of Partie					_ 1 □ YES 2			COMPLETION OF CAUSE OF DEATH?		
Æ	Ciale (ce U					_			YES 2 NO		
ž I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	TH YE	S 🗆 NO 🗵	UNCE	RTAIN						
호	EXAMINER? HOSPITAL:	E OF DEAT	OTHER:								
PHYSICIAN:	1 VES 2 NO 1 Input on 2 ER/Output 3		4 - Nursing Home		Idenca 6	Other (Specify)					
	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year)	28b. TIM INJ	URY WO	RK?		d. DESCRIBE HOW IN	JURY OCC	CURED			
B	2 Accident Investigation		M 1 7	ES 2 🗌							
	3 Suicida e Could not be determined 200. PLACE OF INJURY — At hor building, atc. (Specify)	me, tarm, a	itreet, factory, office		28	 LOCATION (Street er City or Town, State) 	nd Number	or Rural Rou	ute Number,		
4	29e. CERTIFIER										
ĕ II	(Check only CERTIFYING PHYSICIAN: To the best of my knowledge, de										
COMPLETED	MEDICAL EXAMINER: On the basis of axaminetion end/or i	nveatigatio	n, in my opinion, de	ath occure	d at the time	e, date end piece, and	dua to th	e ceuse(e) a	and mennar ee stated.		
BE (29b. SIGNATURE AND TITLE OF CERTIFIER	20		29c. LICEN	SE NUMBER	R	29d. DATI	E SIGNED (A	Month, Day, Year)		
2	W MW Soul 1	V/		/	708	118	> 3	2/17	195		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED GAUSE OF DEATH (ITEM	4 27) (Type,	Print)	~	10	~ . / /	10	/	,		
	William HWOOD JV				15	ICN 1	Vid	5	1607		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	4 .4									

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. Hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF H	EALTH AND I	MENTAL HYGIEN				
	1. OECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH	AY YE	3. TIME OF DEATH						
		ARY 8. AGE (1)	n yrs. lest birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	7 9	BIRTHPLACE (State or Foreign		
	180-16-8216	□ M 2√XF	74 YRS.	(Month, Day, Year) NOV. 28, 1	(Country) [ARYLAND]				
~	9a. FACILITY NAME (If not institution, give street			9c. COUNTY						
DIRECTOR	HOWARD COUNTY GEN	ERAL HOSPIT	AL	COLUM	BIA		HOWARD			
REC	10a. STATE 10b. COUNTY		10d. INSIDE CITY LIMITS?							
	MARYLAND HOWARD)	CC	DLUMBIA	, ZIP CODE		lien en en	₩X YES 2 □ NO		
FUNERAL	6095 majors LN.				21045		US.	OF WHAT COUNTRY? Δ		
FUN		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		14. RACE — American Indian, Bleck, White, atc.		
ВУ	3 Widowed 4 Divorced	FORCES? 1 YES	TES		2X NO Specify			Specify: BLACK		
ED	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION ripleted)	16a. DECEDENT'S	USUAL OCCUPATIO	ON et of working	16b. KINO OF BUS				
) E	Elementary/Secondary (0-12)	College (1-4 or 5+)		rork done during mo- e retired.)	at or working	DIRECTOR		MMUNITY		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	lyr	SOCIAL	WORKER	18. MOTHER'S NAI	SOCIAL ME (First, Middle, Maiden				
BE C	ANDERSON WARD				MAUDE	A. ROLLEY				
5	19a. INFORMANT'S NAME (Type/Print) ROMAINE MITCHELL					Route Number, City or Town				
	20a. METHOD OF DISPOSITION	20h	D464 PLACE AND DATE O			OATE 20c. LO	CATION — City			
	1 X Burial 2 Cremation 3 Ramoval 4 Donation 5 Other (Specify)	from Stata ceme	ETHEL CE	her plecel		B. 23.1995		IDGE, MD.		
	21. SIGNATURE OF FUNERAL BEHVICE LICEN	SEE			D ADDRESS OF FAC					
	11			P.0	BOX 168	87. EASTON	. MD	21601		
	23. PART I. Entar the diseases, or com shock, or heart failure. List	plications that caused tonly one cause on ea	the death. Do not the line.	ot enter tha mo-	de of dying, auci	h aa cardisc or reapl	ratory arreat,	Interval Between		
	IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	SEPSIS						Onset and Daath		
	resulting in death) / a	SEPSIS DUE TO (OR AS A	CONSEQUENCE OF): [′]			/ .	2		
NO NO	Sequentially list conditions, b.	DUE TO (OR AS A	CONSEQUENCE OF	CUS UI	RINAMY	TRACT IN	feorio.	N		
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury							į.		
CERTIFICATION	that initisted events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):						
	d									
CAL	PART II. Other significant conditions of Ischemic Con	ontributing to death bu	t not resulting in	the undarlying	cause givan in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
Ē		TURET 110	29 01	36/12		1 YES 2	MINO	COMPLETION OF CAUSE DF DEATH?		
N.	DID TOBACCO USE CONTRIB		DEATH YES	S D NO D	UNCERTAIN	10		1 TYES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	QSPITAL:	6. PLACE OF DEAT	H (Check only one)						
HYS	1 TYES 2 NO 1		tlant 3 DOA	4 - Nursing Home	5 Residence	8 Other (Specify) 28d. OEŞCRIBE HOW II	HIEV OCCUE			
ВУ РІ	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		RK?	200. OEŞCHIBE HOW IP	IJOHY OCCORE	- 0		
- 1	3 Suicide 8 Could not be datarmined	28e. PLACE OF INJURY - building, atc. (Specif	— At home, term, st	reet, factory, office	,	28t. LOCATION (Street a City or Town, State)	and Number or R	iural Route Number,		
COMPLETED	(Check only							iuse(a) and manner se stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER	1 , 1	V- 4		29c, LICENSE NUM			GNED (Month, Day, Year)		
D BE	Maurice C	ypea	M)		D381	And the second s	D 2/	17/95		
2	30. NAME AND ADDRESS OF PERSON WHO CO				MSIA	44.0 12:0	1.00			
	31. DATE FILED (Month, Day, Year)	SOSANTIAL 32. REGISTRAR'S SIGNA	TURE	D Call	775117	MO 210	45			
	FFR 9 1 1995	Jahr Stevels	or Rodall							
	40 61 1333									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

) THE HOSPITAL OR ATTENDING PHYSICIAN: The Law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should	siled within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H			IYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)			4	1	2. DATE OF	DEATH		3. TIME OF DEATH		
	JAMES	LEE		Carr	LER	TELORUC	DAY 15, 19	995	1445 M		
		- ALA	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF I	SHRIH V Year)		IPLACE (State or Foreign		
	220 27 1377	1 🔀 M 2 🗆 F	65 YRS.		R LOCATION OF D	NOV. 5	, 1927	927 VIRGINIA			
œ	9a. FACILITY NAME (If not institution, give stre		9c. COUNTY OF DEATH								
ŌT:	PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMIC										
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION				10d. INSIDE CITY		
	MARYLAND SOME	RSET	ED	EN					LIMITS? 1 YES 2XXNO		
3AL	10e. STREET AND NUMBER			10f	ZIP CODE		10g. CI	TIZEN OF WHAT COUNTRY?			
BY FUNERAL	32032 FLOWER HIL				21826			USA			
5	1 Never Married 2 7 Married	12. WAS DECEDENT EVER IN FORCES? XX YES	2 NO	If yes, spi	ENDENT OF HISPA	an, Puerto Ricar	pecify Yes or No-	14. RACI Blec	E — American Indian, k, White, atc.		
	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES	1 🗌 YE\$	2X NO Specif	fy:		Spec	w: BLACK		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION COMPANY OF THE PROPERTY O	16a. DECEDENT'S L	SUAL OCCUPATION	IN .	16b. KIN	D OF BUSINESS/II	NDUSTRY			
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo- retired.)	st or wonung						
MP	2nd		LABORE	R		P	ERDUE FA	RMS			
	17. FATHER'S NAME (First, Middle, Last) GEORGE EDWARDS						e, Maiden Surname)				
B	19a. INFORMANT'S NAME (Type/Print)		105 11411 1110	DD0000 (0)			BECKETT				
2	LOUVENIA J. SMI	тн			NUMBER OF RURE				INIA 25064		
	20a. METHOD OF DISPOSITION	20b. F	PLACE AND DATE OF	F DISPOSITION /Na	me of	DATE	20c. LOCATION -	- City or To	own. State		
	1 X Burial 2 Cremation 3 Remov	al from Stata cerpe	ARYLAND	VETERAN.	S CEM. F	EB.21.	95 BEU	ILAH.	MD.		
	21. SIGNATURE OF FUNERAL SERVICE LICES	HSEE		22. NAME AN	D ADORESS OF FA	CILITY					
	1/2/				NIE SMIT . BOX 16				501		
	23. PART I. Enter the diseases, or co	mplications that caused	the death. Do no	ot enter the mo	de of dying, suc	ch an cardiac	or respiratory a	rreat,	Approximate		
	ahock, or haart fellure. Li IMMEDIATE CAUSE (Finel	at only one cause on and	ch line.			_			Interval Between Onset and Death		
	disease or condition resulting in death)	Mr. Land	dical	in	Porchu	ふ			minl		
		DUE TO (OR AS A	CONSEQUENCE OF	: /					,		
NO	Sequentially list conditions, b.	as will	12						DRUS		
ATI	If any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A C	JUNSEOUENCE OF)	:							
FIE	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF)	:					1		
CERTIFICATION	resulting in death) LAST										
2	PART II. Other algolificent conditions	contributing to death but	t not regulting in	the underlying	ceuse alven In	Part I 24-	. WAS AN AUTOPSY		W		
CAL			t not readiting in	the underlying	couse given in	Part 1. 248	PERFORMED?	246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ED						_ [10	YES 2 NO		OF DEATH?		
2	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAIL	N []			1 YES 2 NO		
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL	20	. PLACE OF DEATH		OTTOLKIZA						
Sic		HOSPITAL:		OTHER: Nursing Home	5 - Rasidence	8 Other (Sp.	eclfy)				
E	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME		JRY AT	28d. DESCRIE	BE HOW INJURY OF	CCURED			
1 Naturel 5 Pending (Month, Dey, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO											
	3 Suicide 8 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY — building, atc. (Specify	At home, farm, st	reet, tactory, offica		281. LOCATION City or Tox	N (Street and Number wn, State)	er or Rural F	loute Number,		
4											
COMPLETED	(Check only	AN: To the best of my knowled On the besis of examination a) and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER	111			29c. LICENSE NUI				(Month, Day, Year)		
O BE	W/ NU	4			029	149	•	2/15	196.		
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DEAT	H (ITEM 27) (Type, I	Print)				/ /			
	William Robins	1104 Health	my DRIS	SAT	sbury. 1	nd a	1801				
	31. DATE FILED (Month, Day, Year) FFR 2.1 1995	32 REGISTRAR'S SIGNAT	Kardall								

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Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 uted within 24 hours after death, completely filled in by the funera

Pages 1, 2, 3 should

permit.

funeral director, page 5 should be detached for use as the burial-transit

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 his	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the r

95 07756 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1995 BERTHA **EMMA** 4:40 p m 24 Feb. CHAPLAIN 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH
(Month, Day, Year)
MAY 9,1903 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 - M 2 X F YRS. 213-18-5450 91 MARYLAND 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MEMORIAL HOSPITAL EASTON TALBOT 10a. STATE 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND TALBOT EASTON 1X YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? WILLIS AVENUE 21601 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married 1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced WHITE ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8 SEAMSTRESS GARMENT 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname, BE GEORGE EMERSON WATTS DAISY VAUGHN SARD 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 STARKEY DAISY C. WILLIS AVE., EASTON, MD 21601 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 19 Burial 2 Cremation 3 Removal from State SPRING HILL CEMETERY 2-28 Donation 8 - Other (Specify) __ EASTON, MD 21601 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. Newnam 51 200 S HARRISON ST., EASTON, MD 21601 23. PART i. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata ehock, or heart fallure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel **Onset end Death** disease or condition hr resulting in death) DUE TO (OR AS A CON

Rena CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSTOUENCE OF) cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Hornia ialus 1 TYES 2 NO OF DEATH? Jama 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined

29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as attend.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

D41723

296. SIGNATURE AND TITLE OF CERTIFIER	1/2	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) hrustados8

33. REGISTRAR'S SIGNATURE July Shewson Rawfall

DHMH-18 Rev 1/89

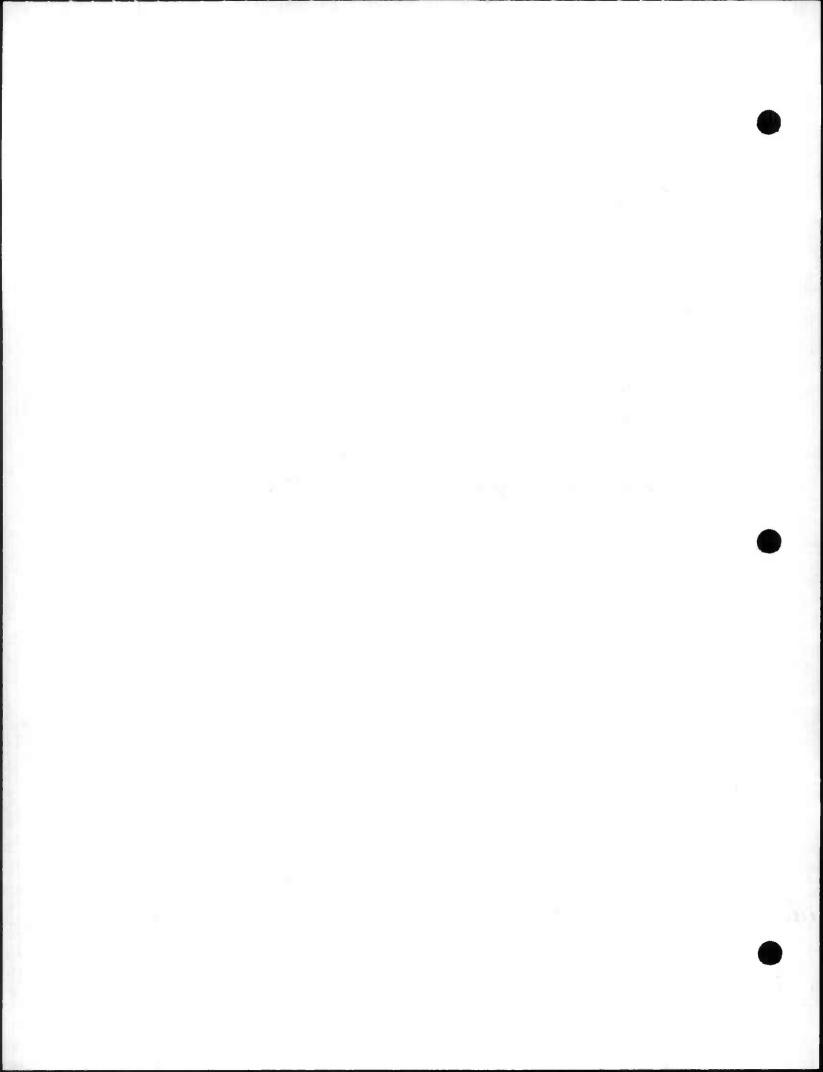
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	9
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	POTATO OF ATTENDING PROPERTY. The Jan store of Land Asset Land Company

REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 YEAR DAY MÄRCH HORACIO **CADENA** 1, Αı 1:30 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Feb. 7, 1 M 2 - F 215-54-9836 59 1936 Colombia Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 14320 Rose Tree Court Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Silver Spring t permit. 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14320 Rose Tree Court use as the burial-transit 20906 Colombia retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) X YES 2 NO BΥ Specify: 3 Widowed 4 Divorced Colombian White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 10 Owner Reupholstery once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) to Ricardo Cadena BE Maria Antonia Chacon notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Alfredo Cadena (Son) 134 Duvall Lane, Gaithersburg, MD hours after death. Page 6 may be e 20a. METHOD OF DISPOSITION
1 |X Burlal | 2 | Cremation | 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must funeral director, Garden of Peace 4 Donation 5 Other (Specify) 3-6 Bogota, Colombia 21. SIGNATURE OF FUNERAL SERVIGE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. Thomp 933 Gist Ave, Silver Spring, MD 朝 20910 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximata shock, or hasrt failure. List only one cause on each line. Interval Betw 9 IMMEDIATE CAUSE (Final Onset and Death disesse or condition cremation. and completely fil o burial, cremation Malignant Melanoma 3 years event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. 2 DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediata cause. Enter UNDERLYING physician CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST signed by the attending I Health and Mental Hydien 9 In uny, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 YES 2 XNO shows a 1 YES 2 XNO t. of P DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate the State HOSPITAL: OTHER: 1 YES 2 X NO 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Realdence 8 ☐ Other (Specify) 10 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED. this (marked. 1 X Natural 5 Pending Investigation 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 19 COMPLETED 6 Could not be DIRECTOR: / 4 Homicide 28 Item HOSPITAL FUNERAL I WITHIN 72 I = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the tion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 8 29d, DATE SIGNED (Month, Day, Year) Muhaels DC19757 March 1, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D. Michael J. Hawkins. 3800 Reservoir Road, NW. Washington, DC 20007 31. DATE FILEMAR DO 1501 1995 32/hegistone's signatures Julia Davidson Randall



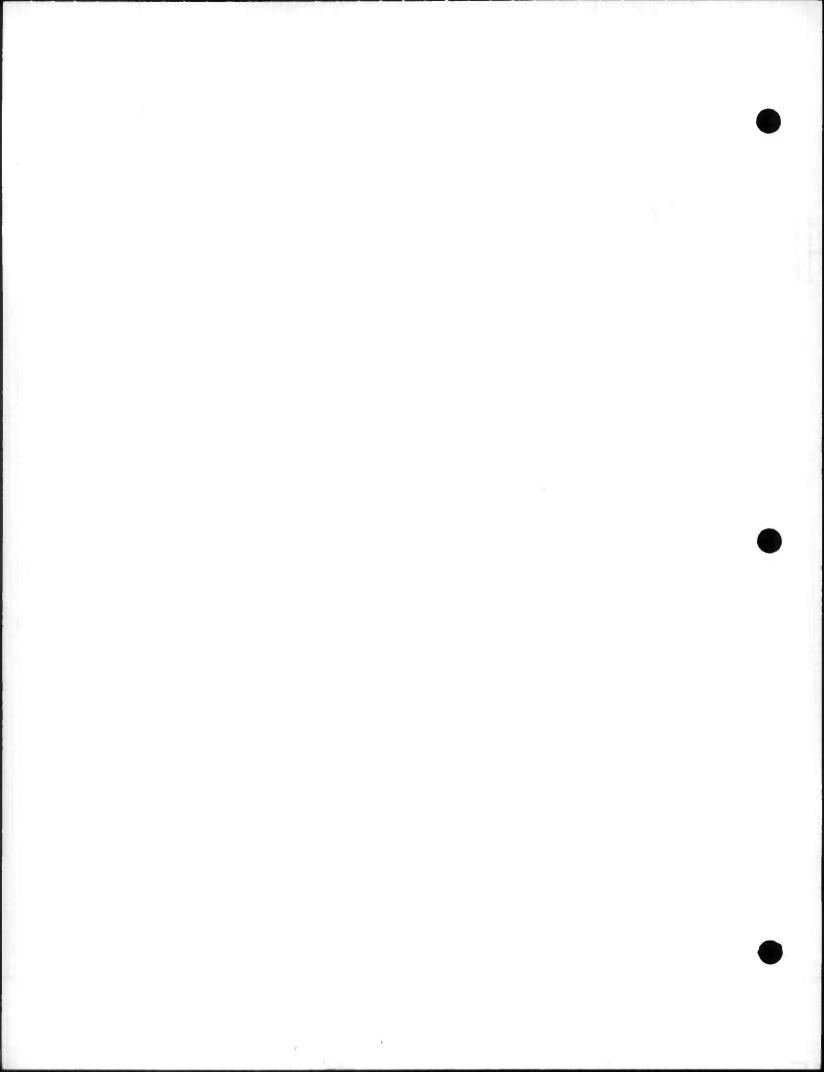
attending physician. use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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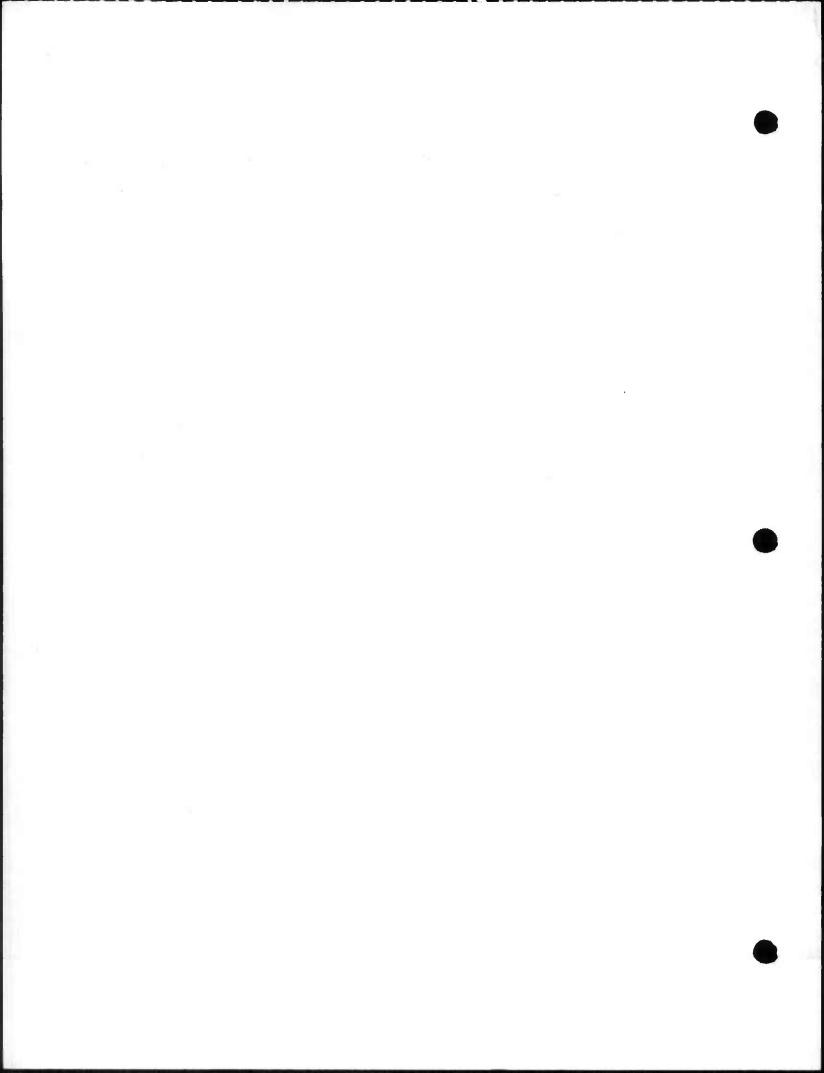
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	1. DECEDENT'S NAME (First, Middle, Last)			OF DEATH		1 :	3. TIME OF DE	EATH			
	Mary V	Virginia Cox				MAN		1995	YEAR	1:50	P w
6			n yrs. lest birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	OF BIRTH	8. BIRTHPLACE (Foreign	
	577-84-3435	1 □ M 2 😡 F 92	YRS.	MONTHS DAY	S HOURS MIN.		h, Day, Year)		Country)		
	9a. FACILITY NAME (If not institution, give street	Y OF DEA		, DC							
DIRECTOR	Holy Cross Hospital Silver Spring Montgon										
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	Maryland Monto	gomery		Beth	esda				١,	LIMITS?	X NO
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₽ P	12		Homen	aker			Own	Home			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, i	Middle, Maiden	Surname)			
BE	William S. McCart	hy			Mary	Harv	ey				
5	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Num	ber, City or Town	n, State, Zip C	ode)		
-	Olive Louise Coffr	ren	7912	Kentbu	ry Drive,	Bet	hesda,	Mary!	land	2081	4
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remove	20b.			arch 3, 1						
	4 □ Donation 5 図 Other (Specify)Ent(ombment Ga	te of He	aven M	ausoleum	1	Sil	ver Sp	pring	,Mary	land
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE		22. NAME	AND ADDRESS OF FI Tt A. Pum Betheso Wisconsi	ACIUTY	v Fune	ral W	ome /		
	Koul to	mh	M00198		Betheso	la-Ch	evy Ch	ase,	Inc.		
	23. PART I. Enter the diseases, or cor	nplications that caused	the deeth. Do n	ot enter the	Wisconsi	n Ave	e Bet	nesda,	MD	20814 Approxi	
	ahock, or heert failure. List IMMEDIATE CAUSE (Fine) disease or condition resulting in death) a.	Capus	Sea P	una	u .			alory arres	,	Interval	Between nd Death
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N N	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEAT	H (Check only o							
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B	2 Accident arvestigation 200 BLACK OF IN MIDN. As here of the second sec								te Number		
Ĕ I	8 Could not be determined Similar and Number or Rural Route Number, State and Number or Rural Route Number, City or Town, State)										
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	296. SIGNATURE AND TITLE OF CENTIFIER				29c, LICENSE NU	MBER		29d DATE 9	NGNED (M	lowth, Day, Yea	e)
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유	30. NAME AND ADDRESS OF PERSON WNO C	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type.	Print)) 2	Q CVIANE	-,50		7'			
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	31. DATE FILED (Month, Day, Year)	12. REGISTRAR'S SIGNA	TURIE	· ·	14/100/	1110	7				
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			4 DECEDENTIA MANG (C)						IOAII		DEA		_	HEG. NO.			
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pino		į.	212-66-3801 9e. FACILITY NAME (# not #	nstitution, give s			40		9b. CITY	TOWN	OR LOCATE	ON OF DE	May	15, 19		Vashi	ngton, DC
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MARY retained b	2 6	4	Cornelius 190. INFORMANT'S NAME (1		ullivan		196	MAILING	ADDRESS	(Street a		rici		er, City or Town	ung	Code)	
M/ e reta	힐	2	John	Cunnin	oham		- 1							pring,			1/4
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ALTIMOR leath. Page 6 m; funeral director,	examiner must	- 1	4 Donation 5 Other	(Specify)	\sim	- Pa	netery, crer rkla	matory or o Wn M	emor	ial	Gard	ens	3/4	Rock	ville	, Ma	ryland
Pa Pa	a la	Н	21. SIGNATURE OF TURERA	L SERVICE LIC	ENSEE)				22.	NAME A	NO ADORE	SS OF FA	CILITY				
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physic by the funeral director, page 5 should be detached for use as the burial noval.	exa		· 160	US	Pu	16								ral Ho lver S			
hours after of in by the	dica	T	23. PART I. Enter the d	Iseesea, or o	omplications the	t cause	d the dea	ath. Do r	not enter	the mo	de of dyl	ing, auci	h aa card	lac or reapli	ratory arre	ent,	Approximate
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.O. B. certificate ding physi lygiene pr	other	É	CAUSE (Disease or injuthat initiated events		DUE TO	(OR AS A	CONSEO	UENCE O	F):								
		5	resulting in death) LAS	T (d												
DS, P the death the atten d Mental	31	- 14	PART II. Other algolitica	int condition	s contributing to	death b	out not re	eaulting	In the un	deriving	g cause o	alven in	Part I	24a. WAS AN	MITTOPSY	245	WERE AUTOPSY FINDINGS
C = 6 5	ini ku sw	5	Seizures								g outday t	give in in	= 1	PERFOR	MED?		AMILABLE PRIOR TO COMPLETION OF CAUSE
S S S S	ទ្ធ ជ	3	A- 12	0.1	en Rat	2	F	1	/				- 1	1 TYES 2	M) NO	- 1	OF DEATH?
L REC law requires as been sign bept. of Healt	<u>ء</u> ا ۽		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USF C	OF DEAT	TH AF	S 🗆 1	NO F	1 LINC	ERTAIN	V M				1 - YES 2 - NO
OF VITAL RE rSiCIAN: The law requ s certificate has been th the State Dept. of h	r item 23 sh	Ž	25. WAS CASE REFERRED TO EXAMINER?						TH (Check		2 0110		77.1				
VIT IAN: 1 tifficat e Sta		ź	1 YES 2 NO		HOSPITAL:	ER/Out	patient 3	□ DOA	OTHER		e 5 🗆 Re	sidenca	6 Other	(Specify)			
DIVISION OF VITA THE HOSPITAL DR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate In filed within 72 hours after death with the State D	. 3	E	27. MANNER OF OEATH Natural 5	D	26s. DATE OF (Month, D			28b. TIM INJ	E OF URY	28c. INJ WO	URY AT		28d. DE\$	CRIBE HOW IN	JURY OCC	URED	
OING P	marked			Pending Investigation					М		YES 2	NO					
TTENDI TTOR: A after of	28 18	3		Could not be determined	28e. PLACE O building,	etc. (Spec	cify)	ne, farm, s	street, tect	ory, offic	•		281. LOCA City o	TION (Street as	nd Number o	or Rural Ro	ute Number,
DIVISION OR ATTENDING DIRECTOR: After hours after death	ANT: If Item 2	. II	29e. CERTIFIER														
TAL C			(Check only		CIAN: To the beat of												end menner ee stated.
TO THE HOSPITAL. TO THE FUNERAL, be filed within 72 !	AN S	\mathbb{H}				Zanimiano.	il enador il	weatigatio	m, in my o	piriion, a				end piece, end	due to the	cause(s)	end menner ee stated.
THE BE	POR P	V	b. SIGNATURE AND TITLE	OF CERTIFIER							29c. LICE	NSE NUN	ABER		29d. DATE	SIGNED (Month, Day, Year)
663	≅ ¢	2	30 NAME AND ADDRESS OF	F PERSON WHO	O COMPLETED CAU	SE OF DE	ATH (ITEM	27) (Trans	Print)		0.3	60 X	45		11/1	+ RCM	1/178
/		V	MAI-CHI		YEN 1	n.O	//			+ 41	o Pa	41.	0411	PKU	1111	0/	2/04/
d			31. DATE FILED (Month, Day,	Year)	32 REGISTRA	R'S SIGN	ATURE	55,		1//	113	IUV	NIVI	PKU	9 0	11 (//	120/54 ////
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29b. SIGNATURE AND TITLE OF CERTIFIER

Steven 31. DATE FILED (Month, Day, Year) MO

32. REGISTRAR'S SIGNATURE

Develor Revolate

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Geller

1995

permit. Pages 1, 2, 3 should for use as the burial-transit ours after deem Page 6 may be retained by the hospital or attending physician. completely filled in by the human effector, page 5 should be detached inial, cremation, or removal once. at notified pe must examiner the medical event, bunal, traumatic and item 23 shows any injury, or other the signed by the Health and I has been 28 is marked, DIRECTOR: If item FUNERAL (TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

07760 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Feb YEAR 7:00 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 M 2 YRS. 214-20-4773 June 15. 1920 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Howard County General Hospital Columbia Howard 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Rockville 1 YES 2 0 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 727 Harrington Road 20852 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-it yea, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 TYES 2 X NO Specify 8 3 🔀 Widowed 4 🗌 Divorced White ETED. 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 Realtor Real Estate 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Shorb Shipley Lillian Rochelle Maddox BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 M. Carole Day 727 Harrington Road, Rockville, MD 20852 20s. METHOD OF DISPOSITION

1) Burisl 2 Cremetion 3 Removal from State
4 Donation 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Gate of Heaven Cemetery 3/2/95 Silver Spring, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or haart fallura. List only one cause on each line. intarvsi Bstween IMMEDIATE CAUSE (Final Onset and Dasth disease or condition PHYSICIAN: MEDICAL CERTIFICATION

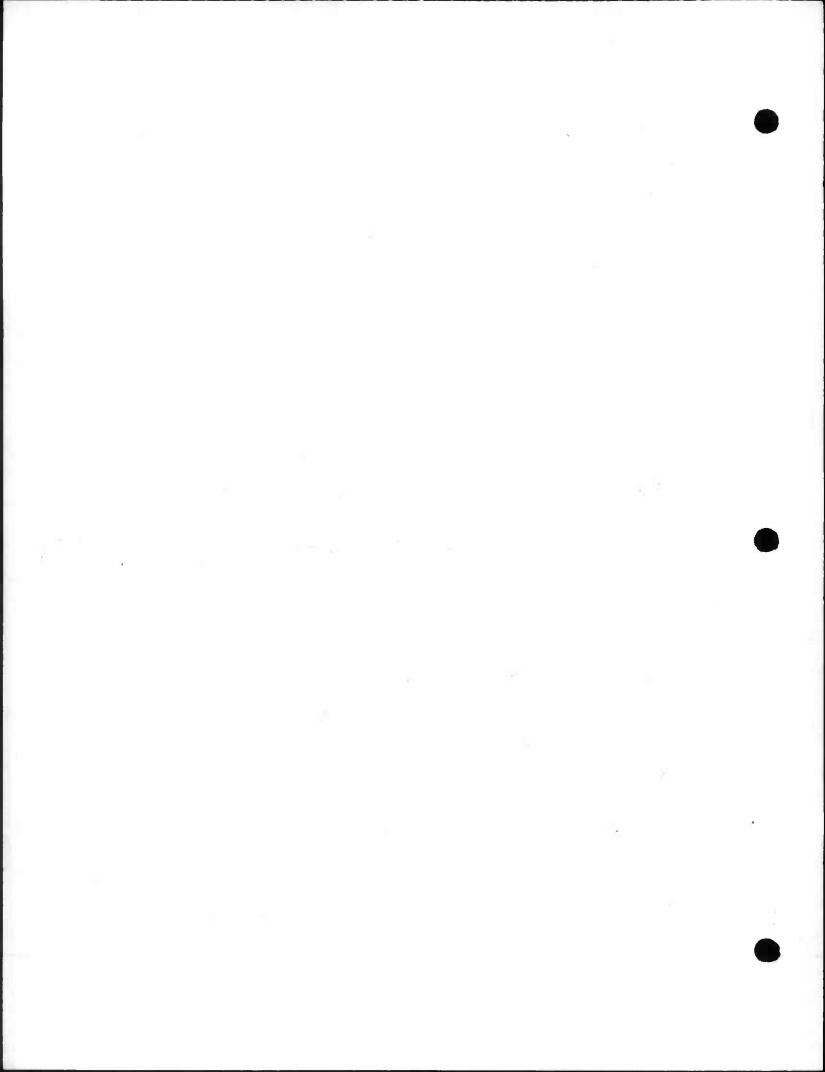
resulting in dasth)	DUE TO (OR AS A CON	ESIVE	neari	railure	Iday
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b DUE TO (OR AS A CON	SEQUENCE OF):			
CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE OF):			
PART II. Other algoriticant condition CellulaTas Of DID TOBACCO USE CONT	Left foot, A	irterial	Insuffi	PERFORMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL	T	LACE OF DEATH (Check			
EXAMINER?	HOSPITAL:	OTHE		nca 8 Other (Specily)	
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW INJURY OCC	CURED
3 Suicide 8 Could not be determined	28a. PLACE OF INJURY — Al building, atc. (Specify)	home, farm, street, fac	tory, office	281. LOCATION (Street and Number City or Town, State)	or Rural Route Number,
one)	ICIAN: To the best of my knowledge, ER: On the bests of exemination and			due to the cause(a) and menner as state	

onth. Day. Year!

29d. DATE SIGNED (M

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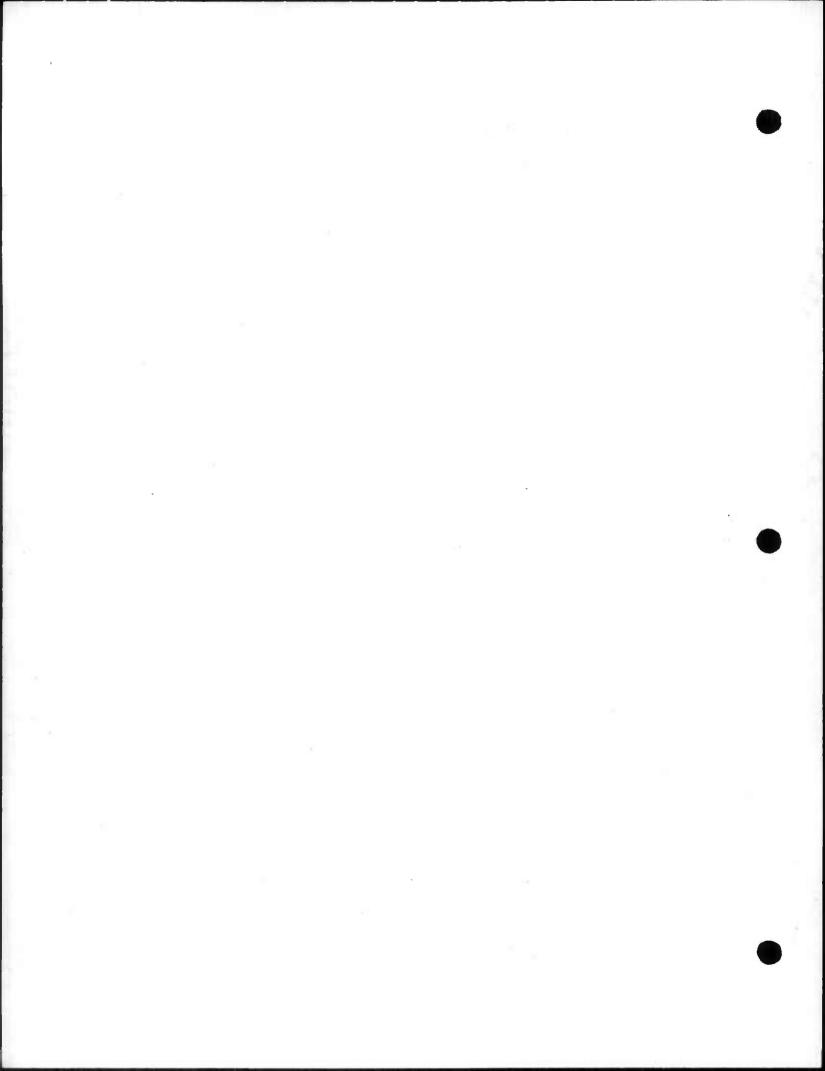
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after deal IMPORTANT; If Item 28 is m:

	2, 3 should	
	ermit. Pages 1,	
physician.	burial-transit p	
or attending	use as the	
he hospital	ctor, page 5 should be detached for use as the b	9990
etained by t	should be	offilled at
e may be r	ctor, page	must be notifi-
death. Page	funeral dire	vaminer :
nours after	ed in by the	medical
neare be executed within 24 hours after death. Pe	ompletely fill d. cremation	event the
e De execut	sician and c	fraumatic
am ceruncai	tending phy.	or other
mar me oe	ed by the al	any injury
saunbai we	is been sign ept, of Healt	23 shows
SICIAN: ITE	Affer this certificate has been signed by the attending physician and completely filled in by the funeral direc beath with the State Dept, of Health and Mental Hydlene prior to burial, cremation, or removal.	or Hern
ING PHY	After this leath with	marked

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND CATE OF DEATH		AL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)			THE OF BEATT	_	E OF DEATH			3. TIME OF DEATH-
- 3	Joseph Michael	Costenhader			MON			EAR 95	5:30
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR				-	PLACE (State or Foreign
	220-38-0921	1, M 2 F	52 YRS.	ONTHE DAYS HOURS M	IN. (Mo	re OF BIRTH 1 C		Country)
	Se. FACILITY NAME (If not institution, give	Δ.		b. CITY, TOWN OR LOCATION (nuary 7,	9c. COUNTY		ington, D.C.
æ	1605 Dublin Driv				JI OLAIII				
DIRECTOR	RESIDENCE OF DECEDENT	<u>e</u>		Silver Spring			Mont	gom	ery
R	10a. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCATION					10d. INSIDE CITY LIMITS?
	Maryland Mon	tgomery	S	lver Spring					1 ₩ YES 2 NO
AL	10e. STREET AND NUMBER			101. ZIP CODE			10g. CITIZEI	OF W	HAT COUNTRY?
FUNERAL	1605 Dublin Driv	e		209	902		U.S	. A .	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II	U.S. ARMEO	13. WAS DECENDENT OF H	SPANIC ORIG	IN? (Specify Year		RACE	- American Indian, White, etc.
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yea, specify Cuban, M		o Rican, atc.)		Specif	
		1968-197						hit	e
COMPLETED	15. DECEDENT'S EDL (Specify only highest grade	e completed)	(Give kind of wo	k done during most of working	11	66. KIND OF BUSI	NESS/INDUS	TRY	
اي	Elementary/Secondary (0-12)	College (1-4 or 5+)							
N N	17. FATHER'S NAME (First, Middle, Lest)	2	Radon Te					Pr	otection
						, Middle, Maiden S	urname)		
B	Joseph E. Coster	nbader				Dennis			
2				DDRESS (Street and Number or F					
	Gary P. Costenbac			ublin Drive					
	1 Burial 2 Cremation 3 Rem	noval from State	setoni organizationi ni othe	DISPOSITION (Name of piece)	1	TE 20c. LOC			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	Me	tropolita	n Crematory		95 Alex	andri	a,V	irginia
		1.		Francis J. (s Funer	al Ho	me.	Inc.
	Jemothe	1 St. Care	sell	500 Univers:	itv B1	vd.W.	Sil.S	pr.	
	23. PART I. Enter the diseasea, or shock, or heart fellure.	complications that caused List only one cause on a	the deeth. Do not	enter the mode of dying,	such as ce	rdiac or reaping	atory arrest	,	Approximate
	IMMEDIATE CAUSE (Final	A 0523					0		Onset and Death
	disease or condition resulting in death)	a. Cor C	inoma	04	Thro	at	Cur		1 ugant
		DUE TO (OR AS A	CONSEQUENCE OF):						9
N	Sequentially list conditions,	b		rand					
Ě	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):)					
2	CAUSE (Disease or Injury	C	00110501151105 05						
Ē	that initiated events resulting in death) LAST	DOE TO (ON AS A	CONSEQUENCE OF);						
CERTIFICATION		d							
AL	PART II. Other algnificant condition	ns contributing to deeth b	ut not resulting in	the underlying cause give	n in Part I.	24s. WAS AN A			WERE AUTOPSY FINDINGS
						PERFORM 1 YES 2 [AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						7			OF DEATH?
-	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO □ UNCERT	IAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH						
SIC	EXAMINER? YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp		THER: Nursing Home 5 Reside	nce 8 🗆 Ott	ser (Snecibi)			
호	27. MANNER OF OEATH	28a. OATE OF INJURY	28b. TIME (OF 28c, INJURY AT	7	ESCRIBE HOW IN.	JURY OCCUR	ED	
ВУ Б	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	WORK? M 1 YES 2 NO	,				
	3 Suicide 8 Could not be	28e. PLACE OF INJURY	- Al home, farm, stre	et, factory, office	281. LO	CATION (Street arr	d Number or I	Rurel Ro	ute Number,
	4 Homicide determined	building, etc. (Spec	ny)		Cir	y or Town, State)			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	adae death coursed	et fhe time, data and place, and	die te this e		S. Slieve		
ž				in my opinion, death occured at				nuno(a)	and manner as stated
	29b. SIGNATURE AND TITLE OF CENTIFIE								
BE	DP.	20.	1	29c. LICENSE			29d. DATE SI		Month, Day, Year) 28 95
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	TH (ITEM 27) (Same 2				7 (-1		28 93
	11 -	The bar		8 Wiscons		Ace	-	2	C_0 40
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN			2,~	Lar	C	2	1200
	MAR 01 1995	Jalia Davidson							
			Adams						





TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.

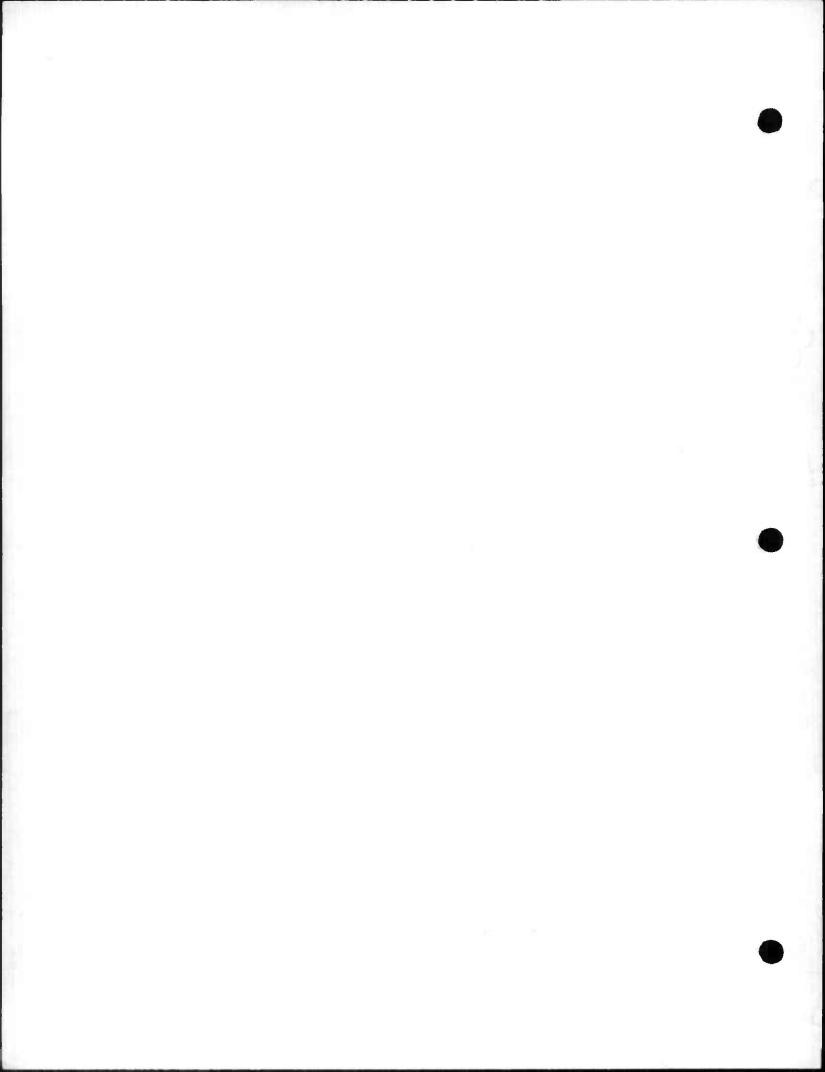
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1	1. 1	DI	ECE	DE	IN	r's	N/	

	REGISTRAN			SEHIIL	ICAI		DEA	i n	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Lest) Yu	Ying C	heung						2. DATE OF DEATH MONTH February	26 1	QYEAR	7:20 Am
	4. SOCIAL SECURITY NUMBER 214-33-0857	5. SEX	8. AGE (In yrs.	^	IF UNDE	ER 1 YEAR		24 HRS.	7 DATE OF BIRTH		a guerrun	LACE (State or Foreign
		1 🗌 M 2 🔀 F	01	U YRS.					(Month, Day, Year) October 2	1,19	4	China
~	9a. FACILITY NAME (If not institution, give at				9b. CIT	ry, TOWN	OR LOCATI	ON OF DE	ATH	9c. COU	NTY OF DE	ATH
DIRECTOR	Circle Manor Nurs	ing Home			Kensington					Mont	tgome	cy
EG C	10a. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOC	ATION					IOd, INSIDE CITY
<u></u>	Maryland Montg	0.000.000			Germ						- 1	LIMITS?
	100. STREET AND NUMBER	Omery	-		JC I III	-	of, ZIP COD	F		I ton CIT		YES 2 NO
FUNERAL	12841 Kitchen Hou	se Way						874		log. Gr		
۳ I	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S.	ARMED	12	WAS DE			IIC ORIGIN? (Specify Ye		USA	
	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA	YES 2	NO		If yes, s	pecify Cuba	n, Maxica	n, Puerto Rican, etc.)	0 NO-		- American Indian, White, atc.
B	3 Widowed 4 Divorced	IF TES, GIVE WA	N ON DATES			1 🗆 🕫	R S FINO	Specify	<i>f:</i>		Specify.	Asian
	15. DECEDENT'S EDUC (Specify only highest grade		16a,	DECEDENTS	USUAL C	OCCUPAT	ION	3	16b, KIND OF BU	SINESS/IN	DUSTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)		(Give kind of the Do NOT un	se retired.) auning n	nost of workii	ng				
<u> </u>	N/A	N/A		Homen	ake	r			Own He	ome		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	-					18. MOT	HER'S NA	ME (First, Middle, Maiden	Sumame)		
BE	N/A						N	I/A				
0	19a. INFORMANT'S NAME (Type/Print)								Route Number, City or Tow			
-	Kam Tai Lee		1	12841	Kito	chen	Hous	e Wa	y, Germani	town,	MD 20	874
	20s METHOD OF DISPOSITION 1 \(\tilde{\Omega} \) Buriel 2 \(\tilde{\Omega} \) Cremetion 3 \(\tilde{\Omega} \) Remo	oval from State	20b. PLAC	E AND DATE	OF DISPO	SITION	Vame of		DATE 20c, LO	CATION -	City or Tow	n. State
	4 Donation 5 Other (Specify)		Gate	of H	ëavë	n C	emete	ry 2,	/28/95 Sil	ver	Sprin	g, MD
į	21. SIGNATURE OF FUNERAL SERVICE CIT	ENSEE		22. NAME AND ADDRES					CLITY	Tma		
	A 3 semapor	Joseph			5	00 1	Inive	reit	v Rlud U	oring MD209		
	23. PART i. Enter the diseases, or c	omplications that	caused the	death. Do i	not ente	r the m	ode of dv	ng. suci	h as cardiac or reso	ratory an	rest	Approximate
	anock, or naart failure.	List only one cause	on each li	na.								Interval Between
	IMMEDIATE CAUSE (Final disease or condition	Sepsis	2									Onset and Death
	resulting in death)	v		CONSEQUENCE OF):								Months
-		Ce		brovasculer accident								37
ᅙᆘ	Sequentially list conditions, if any, leading to immediate			A CONSEQUENCE OF):								Years
3	cause. Enter UNDERLYING CAUSE (Disease or injury	1										
	that initiated events	DUE TO (O	R AS A CONS	CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST	ú <u></u> _										
	PART il. Other significent conditions	n contributing to d	eath but not	t resulting	In the u	nderivi	no ceuse o	alven in	Part i. 24s. WAS AN	ALITOPRY	245 9	PERE AUTOPSY FINDINGS
EDICAL		_				,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PERFOR	RMED?	A	WAILABLE PRIOR TO
3									1 _ YES 2	∭ но		F DEATH?
Σ	DID TOBACCO USE CONTR	DIDLITE TO CALL	SE OF DE	ATLI VE	·c []	NO I	71 UNIC	EDTAIN			1	☐ YES 2 ☐ NO
Y V	25. WAS CASE REFERRED TO MEDICAL	GBOTE TO CAU		ACE OF DEAT				ERTAIN	<u>ч </u>			
2	EXAMINER?	HOSPITAL:			QTHE	R:						
PHYSICIAN:	27. MANNER OF DEATH	1 Inpetient 2 E		28b, TIM			me 5 □ Re	sidence	8 Other (Specify) 28d. DESCRIBE HOW I	N HITTO OO	CURER	
	1 Natural 5 Pending	(Month, Day,		INJ	URY	W	ORK?	I NO	200. DESCRIBE NOW I	NJUNT OC	CONED	
à	2 Accident Investigation 3 Suicide Could not be	28e. PLACE OF	NJURY At I	home tarm :				, NO	281. LOCATION (Street)	and Months		A- 81
3	4 Homicide 8 Could not be determined	building, et	c. (Specify)			,			City or Town, State)	ING NUMBER	or Hurai Hou	re Numoer,
<u> </u>	29a. CERTIFIER											
COMPLEI	(Check only one) 29a. CERTIFIER (Check only one)	CIAN: To the best of m	y knowledge,	death occurr	ed at the	time, dal	a and place,	and due	to the cause(a) and mar	nner as stat	led.	
3	2 MEDICAL EXAMINER	1. Of the basis of star	MINERION ENGIO	or investigatio	n, in my	opinion,	death occur	ed at the	time, data and place, an	d due to th	ne cause(s) s	nd manner as stated.
	296 SIGNATURE AND WITLE OF CERTIFIER						29c, LICE D34	NSE NUM	IBER			forth, Day, Year)
5	XAI						ש א	032		⊭ eb	ruary	27, 1995
	Teampe P Acros M					17			MD 2000=			
	Jeanne P. Asner, M				е.,	Ken	singt	on,	MD 20895			
	FFR 28 1995	32. REGISTRAR	SIGNATURE	11								
	FFR 20 1995	YALLA BURNOLL	ac Marks	Late .								



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579-34-7285 DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland permit. FUNERAL 10e STREET AND NUMBER by the funeral director, page 5 should be detached for use as the burial-transit removal. P.O. Box 414 the hospital or attending physician. 11. MARITAL STATUS 1 Never Merried 2 Married BY 3 Widowed 4 ☐ Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade 17. FATHER'S NAME (First, Middle, Last) Page 6 may be retained by * BE notified 19a. INFORMANT'S NAME (Type/Print) Mr Norman Mullen be 20e. METHOD OF DISPOSITION
1% Burlel 2 Cremation 3 Rem
4 Donetion 5 Other (Specify) must examiner 21. SKINATURE OF FUNERAL SERVICE LICENSES nours after death. medical completely filled in by ial, cremation, or remo IMMEDIATE CAUSE (Final disease or condition resulting in death) traumatic event, executed within and com o burial, Sequentially list conditions, inding physician an Hygiene prior to b If any, leading to immediate cause. Enter UNDERLYING 2 certificate CAUSE (Disease or Injury other that initiated events attending (resulting in death) LAST CERI 6 death o the atten Injury, MEDICAL signed by t requires that any Shows PHINCE 14/16.1.415 has been Dept. of h PHYSICIAN: WE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? The r this certificate h Item 1 TES 2 NO PHYSICIAN: the 0 27. MANNED-OF DEATH marked, 1 Natural DIRECTOR: After the hours after death vitem 28 is mark Investigation BY 2 Accident ATTENDING 3 Suicide 8 Could not be determined COMPLETED 4 Homicide OR FUNERAL I HOSPITAL = 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. TO THE HOSPITA
TO THE FUNERA
be filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER BE 2

31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Colucia (eceliA 845 A PEBTUARY 7. DATE OF BIRTH OCT 16, 1918 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 M 2XX 76 YRS. Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF CEATH 9c. COUNTY OF DEATH Shady Grove Adventist Hospital Rockville Montgomery 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Clarksburg Montgomery 1 X YES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20871 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify: Black 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Domestic None 18. MOTHER'S NAME (First, Middle, Meiden Surneme) William Stevenson Leanna 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) P.O.Box 414, Clarksburg, Md 20871 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State Gemelery, cremetory or other place)
Harmony Memorial Park 3/3 | Landover, Md Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between **Onset and Death** VIFAL Meningitis, quer failure 50019 OUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) OUE TO (OR AS A CONSEQUENCE OF): PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS lungestice cuidiomygonthy AWAILABLE PRIOR TO deapets COMPLETION OF CAUSE 1 YES 2 NO of goiter sight 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN 26. PLACE OF DEATH (Check only one) 26. PLACE OF DE
HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28b. TIME OF INJURY 26e. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28e. PLACE OF INJURY --- At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.

D 24398

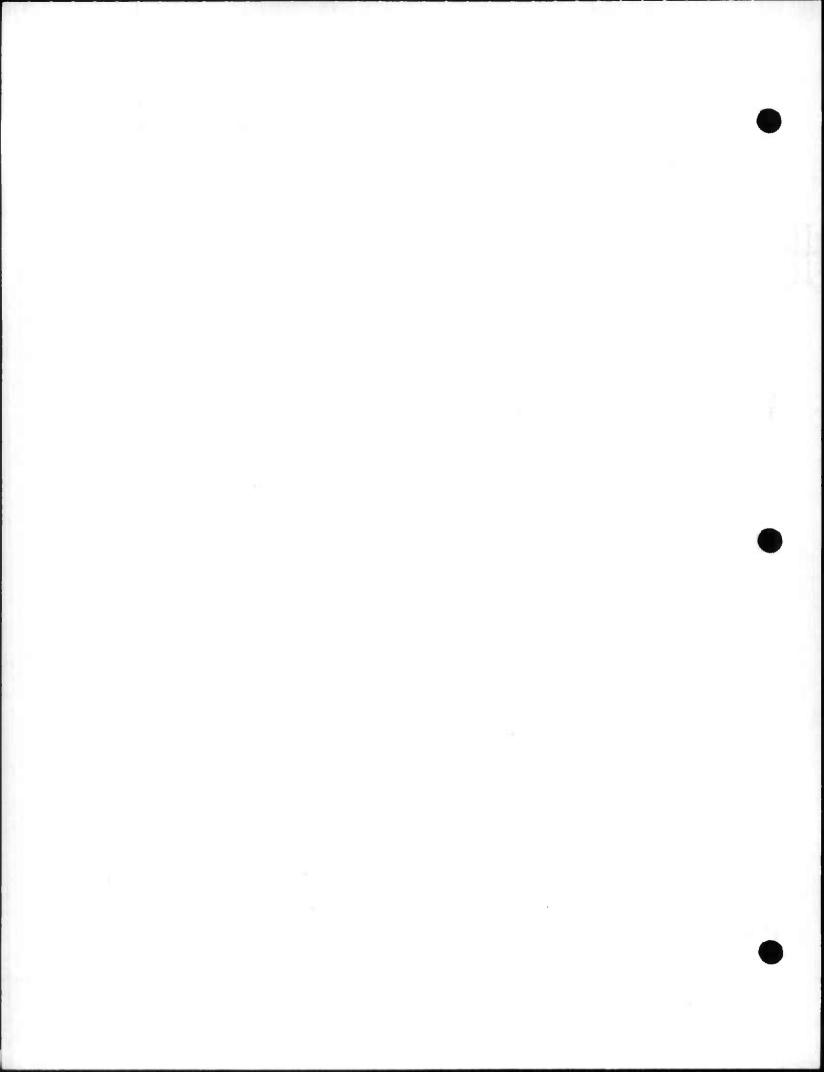
29d. DATE SIGNED (Month, Day, Year) ► 1-Bivary at 1985

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Mich J. SCH N9/2/2 MD 15225 5/1407 GINC 1200 # 302

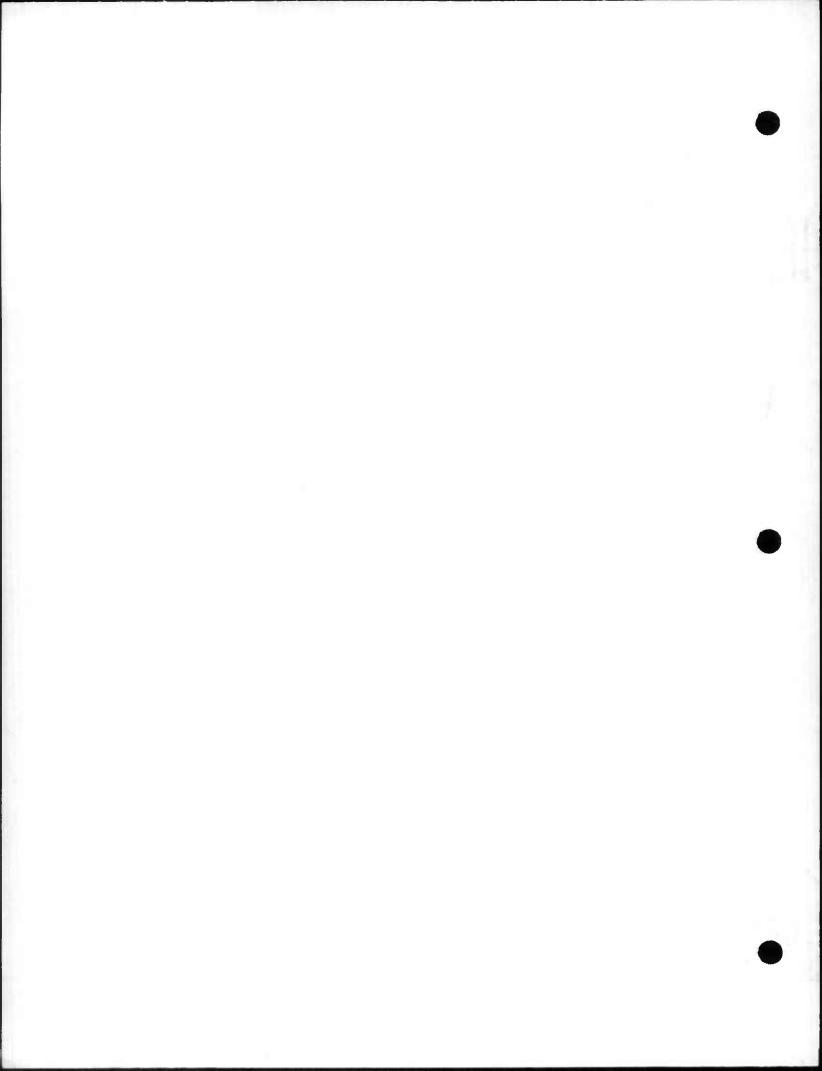
32. BEGISTRAR'S SIGNATURE 28 1995

Julia Davidson Randall



1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAN	_:			CER	THE	CAIL	JF DE	AIH		REG. NO).		
	- 9	1. DECEDENT'S NAME (First,	Middle, Last)			110			_		2. DAT	E OF DEATH	AY	YEAR 3	. TIME OF DEATH
		HELEN	G	[201	IV\ /\	MING	, 5		1	RUARU		995	2:30pm
_		4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In	n yrs. last bli	irthday)	IF UNDER 1 YE	AR IF UN	IDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTHPL	ACE (State or Foreign
-		482-50-1976		1 🗌 M 2 💢 F	8	4	YRS.	MONTHS DA	YS HOUF	RS MIN.		e 16,		Country)	
should		9a. FACILITY NAME (If not ins	titution, give s	treet and number)				9b. CITY, TO	MN OR LOC	ATION OF D		C 10,		ITY OF DEA)Wā
co.	E	Shady Crown	7 2	stick He		1	Ì	D		77-					
1, 2,	DIRECTO	Shady Grove	EDENT	ICISC HOS	SDITA			R	ockvi	тте			Mon	tgome	ry
des	R	10e. STATE	10b. COUNTY	1		1	10c. CITY	, TOWN OR L	CATION					10	Od. INSIDE CITY
£.	<u> </u>	Iowa	Ja	asper				Newto	n					1	LIMITS?
permit. Pages	AL	10e. STREET AND NUMBER						1101101	101. ZIP C	ODE			10g. CITIZ		AT COUNTRY?
	FUNERAL	105 North S	brone	Avenue	Fact	. 754	- ц	20	-	0000					
020 physician. burfal-transit	3	11. MARITAL STATUS	ccona	12. WAS DECEDEN	IT EVER IN	U.S. ARMED	D #			0208	NIC ORIGI	N? (Specify Ye	Unit	ed St	Ates - American Indian,
DPhys burts		1 Never Married 2 1		FORCES? 1				If ye	, specify C	uban, Maxica	in, Puarto	Rican, etc.)		Black, V	White, etc.
21215-0020 If or attending physician for use as the burial-tra	B	3 X Widowed 4 Divon	ced	. , , , , , , ,	WIS ON DA	163		_ ''	1ES 2 &	NO Specif	у:			Specify: Whit	
1215 r atten use as	ETED		DENT'S EDU					JSUAL OCCUI			16	b. KIND OF BU	SINESS/INDE		_e
3	ᇤ	Elementary/Secondary (0-	highest grade	College (1-4 or 5	+)	(Give I life. Do	kind of we NOT use	ork done durin retired.)	g most of wo	orking					
	립			1	<i>'</i>	т	eac.	her				c	chool		
the hos detach	COMPL	17. FATHER'S NAME (First, Mic	idle, Last)				cuo		18. M	OTHER'S NA	ME (First	Middle, Meiden			
A Pe de	1 - 1	Roy R. We:	ston										Gurnamey		
MARYLAND 2. retained by the hospital of should be detached for notified at once.	BE	19a. INFORMANT'S NAME (7/2				19b. M	AILING	ADDRESS /Str	and Alum		ra J	ones aber, City or Tow	o Canto Ti-	0-4-1	
	임	Carol K. Cur	O 111												
		20a. METHOD OF DISPOSITION			200. 4							le, Ma			
BALTIMORE, er death. Page 6 may be the funeral director, page val.		1 Burlei 2 Decreation	3 🗆 Reme	oval from State	ceme	etery, cremate	lory or oth	ner place) Fe	bruai	y 28,	199	95 I	CATION C		
M age		21. SIGNATURE OF FUNERAL	, ,,	ENGEE	- MOI	ntgom	nery	CTGHIC	COLT	ull,	II C	I Bet.	hesda	, Mar	yland
SALTIN r death. Pag e funeral dir al.			SERVICE EIG	CHSEC											y Funeral
		Welman	21	a too	N	M0020	2	Aver	/ KOCI	CATTI	110 110	Maryl	We:	st Mo	ntgomery
ica at		23. PART i. Enter the dis	dasés, or c	omplications the	t caused	the death	n. Do no	ot enter the	mode of	dying, auc	h as car	diac or reap	iratory arre	2850~	Approximate
filled in on, or re		shock, or ha	ert fallure. I	List only one cau	ise on aac	ch lina.							200		intarval Between
withing hour pletety filled I cremation, or vent, the my		disease or condition			C . ~	La		100	-0-	-11-	4.				Onset and Death
3760 rted wittin. completely fal, cremati		resulting in death)	0	DUE TO	(OR AS A	CONSEQUE	NCE OF	in Lux	140	Clas					Stoy he
	,		-					MAHIS							seval
OX 68 e be execute sician and c infor to buris traumatic	CERTIFICATION	Sequentially list condition if any, leading to immediate		DUE TO	(OR AS A	CONSEQUE	NCE OF)	: IIPTI	3(0						years
	N.	cause. Enter UNDERLYIN	IG												
	Ē	CAUSE (Disease or injury that initiated events		DUE TO	(OR AS A	CONSEQUE	NCE OF)	1							
0 - 5 - 5	H	resulting in death) LAST													1
	DICAL	PART ii. Other aignifican	t conditions	contributing to	death bu	t not resu	uiting in	the under	ying caus	e given in	Part i.	24a. WAS AN PERFOR			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
Signed by Health and Health and Iws any	용											1 TYES 2		CC	OMPLETION OF CAUSE F DEATH?
Quires quires n sign f Healt	ME												*		YES 2 NO
W 5 8 0 4		DID TOBACCO US	E CONTR	RIBUTE TO CA	USE OF	DEATH	YES	ON D	₩ UN	CERTAI	νП				
VISION OF VITAL RE ATTENDING PHYSICIAN: The law req ECTOR: After this certificate has been s after death with the State Dept, of 126 is marked, or item 23 sho	SICIAN:	25. WAS CASE REFERRED TO						(Check only			-				
VITA AN: The tificate th e State C or item	Sic	EXAMINER?		HOSPITAL:	ER/Outget	tlant 3 🗆 I		OTHER:	dome # [7	Residence	a 011	ne (Spanië)			
OF V HYSICIA his certif with the ked, or	РНҮ	27. MANNER OF DEATH		28a. DATE OF	INJURY		8b. TIME		INJURY AT			SCRIBE HOW I	NHIBY OCCI	IBED	
NG PHYS fter this eath with		1 Netural 5 🗆 P		(Month, D	ay, Year)		INJU	RY	WORK?					MED	
OF ATTENDING IN DIRECTOR: After Inours after death Item 28 is man	BY	2 Cutalda sm	vestigation	28e. PLACE O	F INJURY -	- At home.	form, sti				281 1 00	CATION (Street)	and Mumbar o	or Priorit Bour	Alumbas
STOR after		_ 0 _ 0	ould not be starmined	building,	alc. (Specify	γ)					City	or Town, State)	Ind Manager C	r nurai nouti) Number,
- K E 3 E	9	29a. CERTIFIER			-										
TAL O	MP.	(Check only		CIAN: To the beet of											
UNEF UNEF ITHIN	COMPLETED	Z MEDIC	AL EXAMINE	s: Un line beale of a	camination	and/or Inves	atigation,	, in my opinio	n, death oc	cured at the	Jime, date	and place, en	d due lo the	cause(a) an	nd manner as stated.
# # # P	BE	296. SIGNATURE AND TITLE C	F CERTIFIER						29c. L	ICENSE NUM	ABER		29d. DATE	SIGNED (MI	onth, Day, Year)
TO THE HOSPITAL OF THE FUNERAL DE THE FUNERAL DE MENTAN 72 HOSPITAL DE MENTANTE HE HE MPORTANT; HE NE		der	sur,	200						PHYIS	57		> Fe	bran	4 26,1995
	2	30. NAME AND ADDRESS OF			SE OF DEAT	TH (ITEM 27	7) (Type, F	Print)							
		IRBY	BERG	ES WO.	80	ov Pc	21/15	WIII	5069	, Rock	<011	le, mi	908	151	
		31. DATE FILED (Month, Day, Ye		32. REGISTRA	R'S SIGNAT	TURE									
		FFB 28 1	995	Ali Davo	bor Ro	roball									l
			YWW /	/											

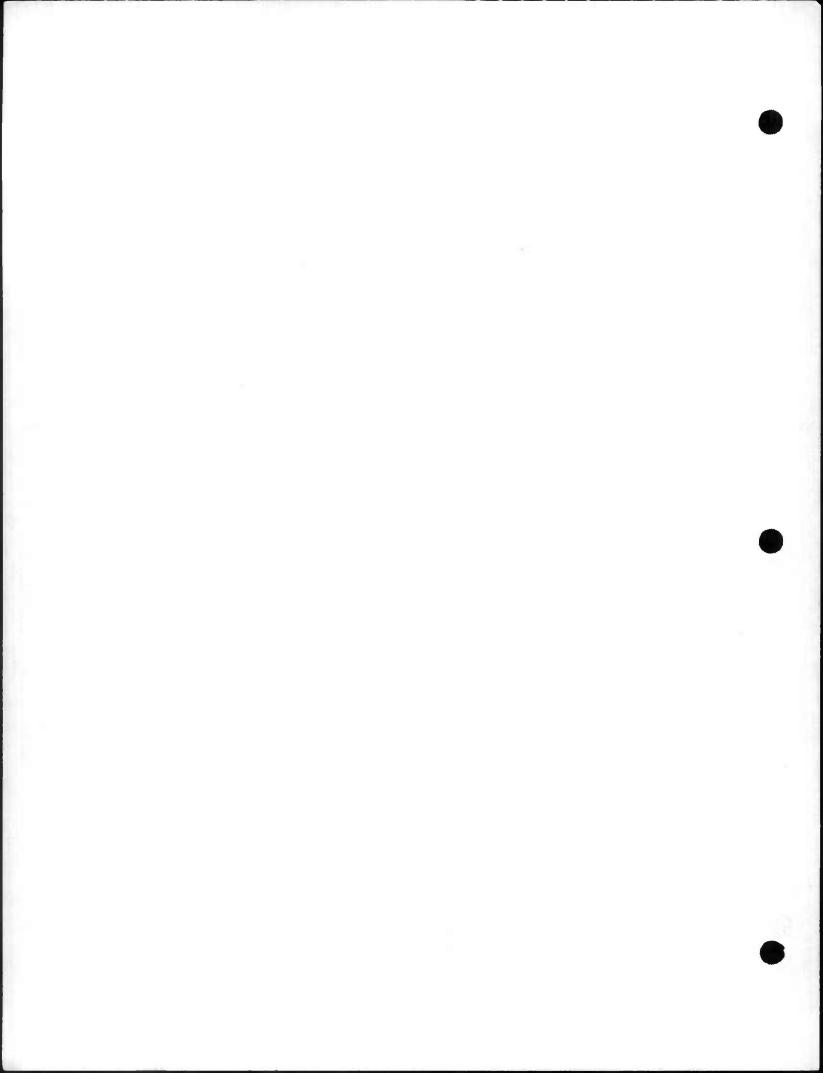


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		1. DECEDENT'S NAME (FIRST, MICH.	plie, Lest)			C	AS	SE		2. DATE OF MONTH	DEATH DA		YEAR 3.	TIME OF DEATH
pir		4. SOCIAL SECURITY NUMBER 579-50-2756	1	SEX	6. AGE (In	yrs. last b	YRS. MONT		B HOURS MIN.	7. DATE OF (Month, Di	Iv. Year)		6. BIRTHPLA Country) MARYI	ACE (State or Foreign
1, 2, 3 should	стов	90. FACILITY NAME (If not institution of the substitution of the s	ITAL	t and number)			96.		N OR LOCATION OF DI HESDA	EATH			TGOMI	
Pages	DIRE	10e. STATE 10b	COUNTY MONTG	OMERY			ROCKV		CATION		•		100	d. INSIDE CITY LIMITS? YES 2 NO
physician. burlal-transit permit.	FUNERAL	6121 MONTROSE	ROAD						10f. ZIP CODE 20852				ED ST	TATES
ding physicia the burlat-tr	BY	11. MARITAL STATUS 1 Never Married 2 Marr 3 Widowed 4 Divorced	rled	2. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	2 NO	D	If yes,	PECENDENT OF HISPAI specify Cuben, Maxica (ES 2 NO Specifi	in, Puerto Rica	specify Yea n, etc.)	or No — 1	4. RACE — Black, W Specify:	American Indian, hite, etc.
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burlat-tran or remonal. medical examiner must be notified at once.	APLETED	15, DECEDEN (Specify only high Elementary/Secondary (0-12) 12		ION npleted) College (1-4 or 5 s		(Give life. Do	DENT'S USUA kind of work of NOT use retir	lone during red.)	NTION most of working	16b. KIP		HOME	STRY	
ed by the hospit aid be detached ad at once.	BE COMPI		ASS						18. MOTHER'S NA SARAH	(UNKI	(NWO			
ay be retained page 5 should t be notified	10	19a. INFORMANT'S NAME (Type/P) TOBA SPITZER 20g, METHOD OF PROSITION		HTER)	100.	137	06 MO	DRAD	WAY, UNIT	#24 5	SILVE	R SPR	ING,	
Page 6 ma director, p		1 A Burlel 2 Commetton 3 4 Donatton 5 Dother (Special Signature of Aumerial Sep	clfy)	1			DOATE OF DIS	ÎÉTER		2/26		CATION — CI		RYLAND
ter death. Page 6 m the funeral director, oval.		· Hate	Th	H	wi	4		DANZA 1170	ANSKY-GOLI ROCKVILLE	BERG N PIKE.	ROC	KVILL	E. MI	
ely fill,		23. PART I. Enter the disease mock, or hear iMMEDIATE CAUSE (Final disease or condition resulting in death)	ses, or com milure. Lia a	t only ona cau	se on aac	C A	NCE		L1V			ratory arre	nt,	Approximate Interval Batween Onset and Death
be execution and or to bur aumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate causa. Entar UNDERLYING CAUSE (Disease or Injury		DUE TO	(OR AS A C	CONSEQUE	ENCE OF):							
the death certificate be ethe attending physician Mental Hygiene prior to njury, or other traum	CERTIFI	that initiated events resulting in death) LAST	d	DUE TO	(OR AS A C	CONSEQUE	ENCE OF):							
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physic be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prival MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other tr	MEDICAL	PART II. Other algorificant or	onditions c	contributing to	death bu	t not rea	uiting in the	undariy	Ing cause given in		PERFOR	MED?	CO	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
he law req e has been e Dept. of m 23 sh	SICIAN: P	DID TOBACCO USE (DICAL				YES C			N 🗆				3.12.14.10
SICIAN: T certificate th the Stat d, or ite	\	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH		OSPITAL: Inpatient 2 =	INJURY		DOA 4 🗆	28c.	ome 5 - Reeldence	8 Other (Sp		JURY OCCU	RED	
NDING PHO R: After this or death with is marke	D BY P	3 Suicide 8 Could	tigation d not be	(Month, Di		At home	INJURY I , ferm, street,	M 1 [WORK? YES 2 NO	281. LOCATIO	N (Street as	nd Number or	Rural Route	Number,
L OR ATTE L DIRECTOI Pours after Item 28	PLETE		mined				occurred at t	he time, d	eta and place, and due			ner as stated	i.	
e Hospita E Funeral d Within 72 RTANT: If	E COMPL		EXAMINER: C						, death occured at the	time, data and	place, end	dua to the	cause(a) and	d manner as stated.
는 다 의 전 은 다 의 전 은 다 의 전 은 다 의 전 은 다 의 전 는 다 의 전 은 다 의	TO B	30. NAME AND ADDRESS OF PER	ISON WHO C	OMPLETED CAUS	E OF DEAT	TH (ITEM 2	7) (Type, Print)		1 1 4	251	8	▶ F	532	-5, 1995
		31. DATE FILED (Month, Day, Year)	SLAN	32. REGISTRA	R'S SIGNAT	TURE	Rock	ULL	LE PI	RE,	Ro	cler	ill	emorop
		FEB 27 199	95 J	lin others	borke	roball								DHMH-16 Rev 1/85

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



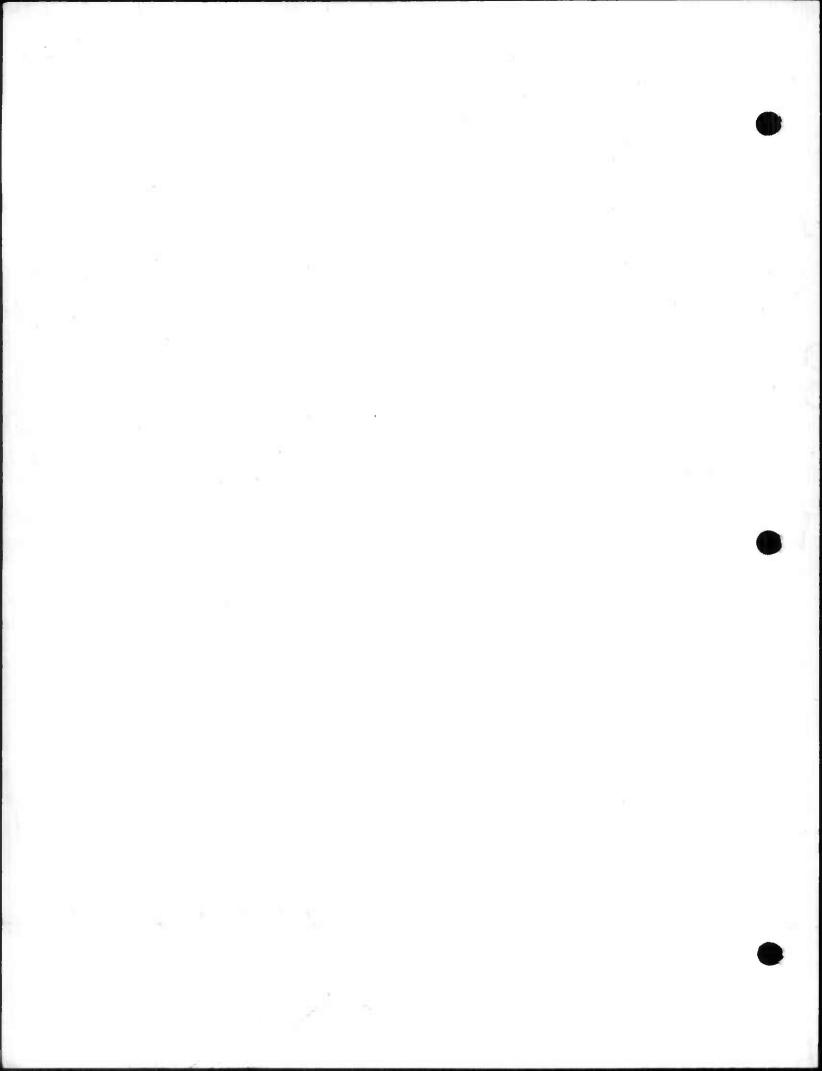
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

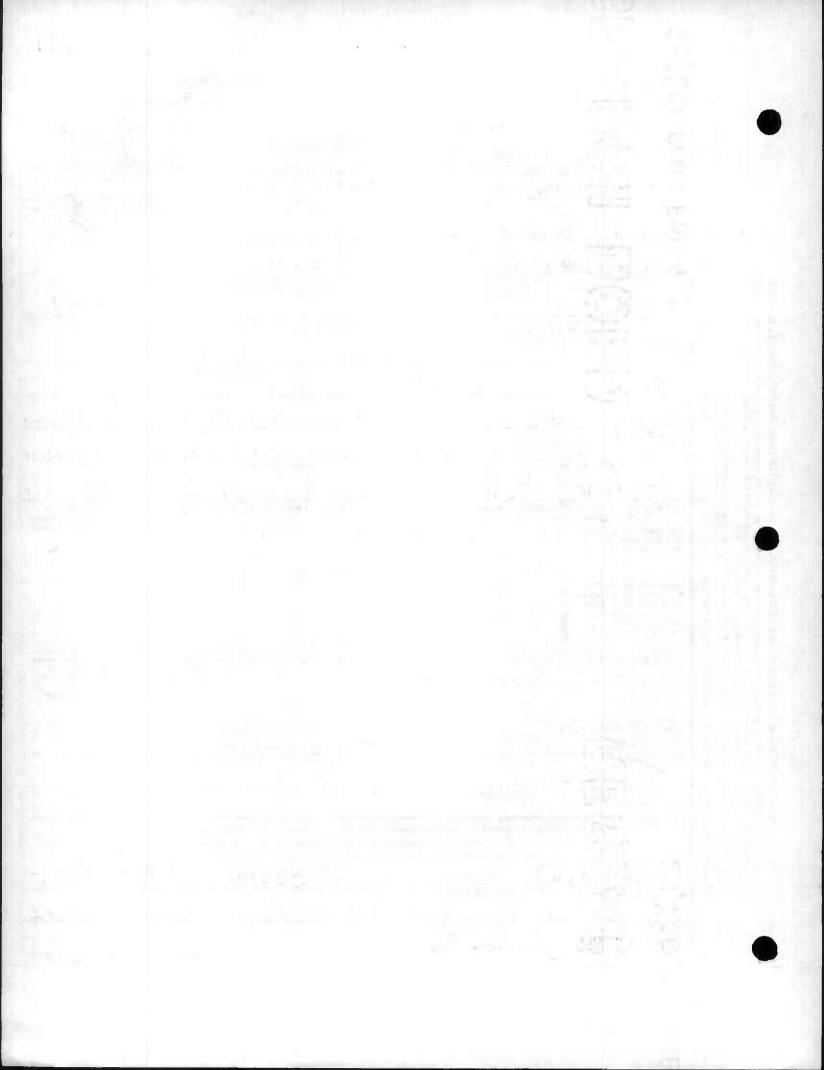
FOR	ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/30/95 t.t	
STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MI	ENTAL HYGIENE

	REGISTRAR		CE	RTIFI	CATE	OF	DEATH	H	R	EG. NO				
	1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF I				3. TIME OF DEAT	Н
	SANDRA LEE	CHANDLE	R						FEB.	10	Š	95	1802	D M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last	birthdev)	IF UNDER 1	/EAR	IF UNDER 24	HRS	7. DATE OF E				PLACE (State or Fo	***
	219-74-0957	1 M 2 TF	37			AYS		BARNI	(Month, Da	(Year)	057	Countr	V)	
	9e. FACILITY NAME (If not institution, give :		37	1.211	at arms				April 4	+, L		<u> </u>	nington,	DC
œ	388 NORTH SUM		201				R LOCATION		ATH			INTY OF D		
0	RESIDENCE OF DECEDENT	MII APT#	201		Gait	hei	sburg	g			MC	NTGO	MERY	
EC	10e. STATE 10b. COUNT	γ		10c CITY	TOWN OR	OCATI	ON .							
FUNERAL DIRECTOR	Maryland Manta												10d. INSIDE CITY LIMITS?	
0	Maryland Montg	omery		Gai	thers								1 YES 2 X	NO
RA							ZIP CODE						HAT COUNTRY?	
핗	388 North Summit						20877						tates	
5	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT E FORCES? 1			13. WA	S DECE	ENDENT OF	HISPAN	IC ORIGIN? (Se	ecify Yee	or No-	14. RACE	- American Indie	п,
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR					2 XNO			, wtc.)		Specil	V-	
													Asian	
	15. DECEOENT'S EDU (Specify only highest grade	CATION completed)	(Gh	kind of wo	SUAL OCCI	JPATIO ing mos	N t of working		16b. KIN	D OF BUS	INESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		Oo NOT use	,									
를		2	Wor	d Pr	ocess	or			Law	Fir	m			
႘ၟႜ	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAI	ME (First, Middle	, Meiden	Sumama)	_		
BE	James A. Causero						Satsu	ıyo	Wal	co				
	19a. INFORMANT'S NAME (Type/Print)		196.	MAILINO A	DDRESS (S	treet en	d Number or	Rurei A	loute Number, C	ity or Town	n, State, Zi	Code)		
2	Linda Anderson		12	108	Fairf	ax	Hunt	Rd.	, Fair	fax	. Va	220	130	
	20e. METHOD OF DISPOSITION	14-2	20b. PLACE AI	ID DATE OF	DISPOSITI				DATE			City or Ton		
	1 Donetion 5 Omer (Specify)	loval from State	Fairfa	x Cr	er place)	rv	2/	12/	0.5	Fair	rfav	Vir	ginia	
	21. SIGNATURE OF FUNERAL SERVICE LA	CENSE	1	01				SS OF FACILITY					ginia	
	× 11. 11 5	Nina					Home,	105	Street					
_	fleef (.	June	_		Fai	rfa	x. Vi	roi	nia 2	2030	1			
	23. PART 1. Enter the diseases, or shock, or heart fallure.	complications that cause	sused the dea	th. Do no	t anter th	a mod	la of dying	, such	as cardiac	or respi	ratory ar	rest,	Approxima	
	IMMEDIATE CAUSE (Final	, , , , , ,	on outfillio.										Interval Ba	
	disease or condition resulting in death)	. UNDETERMI	NED										ĺ	
			R AS A CONSEC	IENCE OF):								_		
z I		h												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OF	AS A CONSEOU	ENCE OF):										
3	CAUSE. Enter UNDERLYING CAUSE (Disease or injury	c.												
<u> </u>	that initiated events	OUE TO (OF	R AS A CONSEOU	S A CONSEQUENCE OF):										
=	resulting in death) LAST	d										1		
- 81														
A	PART II. Other algnificant condition	s contributing to de	ath but not ra	uiting in	tha unde	rlying	cause give	en in F	Part I. 24s.	WAS AN	AUTOPSY	24b.	WERE AUTOPSY FIN	
5									_ 1/2	PYES 2			COMPLETION OF C	
													DF DEATH?	,
-	DID TOBACCO USE CONT	RIBUTE TO CAUS	SE OF DEAT	H YES	Пис		UNCER	PTΔIN					1/2 123 2 110	<u> </u>
₹	25. WAS CASE REFERRED TO MEDICAL				(Check only		OTTOE	XIZ-III V	,		-			
SICIAN: MEDICAL	EXAMINER? 1X XES 2 NO	HOSPITAL:			THER:		****							$\overline{}$
РНУ	27. MANNER OF DEATH	1 Inpatient 2 I El		28b, TIME				lence 8	Other (Spe					
	1 XNatural 5 Pending	(Month, Day,	Year)	INJU	TY.	wor	IK?	.	28d. DESCRIB	E HOW IP	IJURY OC	CURED		
à l	2 Accident Investigation	280 PLACE OF I	1 11 11 11 11 11 11 11 11 11 11 11 11 1	400			ES 2 N	-						
	3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF It building, atc.	(Specify)	e, term, atr	eet, factory.	office			281. LOCATION City or Tox	l (Street e vn, State)	nd Numbe	or Rural Re	oute Number,	
. I														
로		CIAN: To the best of my												
COMPLET	one) 2 X MEDICAL EXAMINE												end menner ee st	rted.
	29b. SIGNATURE AND TITLE OF CERTIFIE		7				29c. LICENS			T			(Month, Day, Year)	
出		410h	1				0.0				▶FE		11,1995	5
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALISE	OF DEATH (ITEM	27) (Turns 0	rint)								,_,	\longrightarrow
	Davill R &	Thelas				eet	. Ra	1]+	imore	. м	arul	and	21201	
- 1	100-010	2 40 UV					,			S AA	~~	- CALLUI	~ I L U I	
1	FEB 27 1995	2. REGISTRAR'S	SIGNATURE											



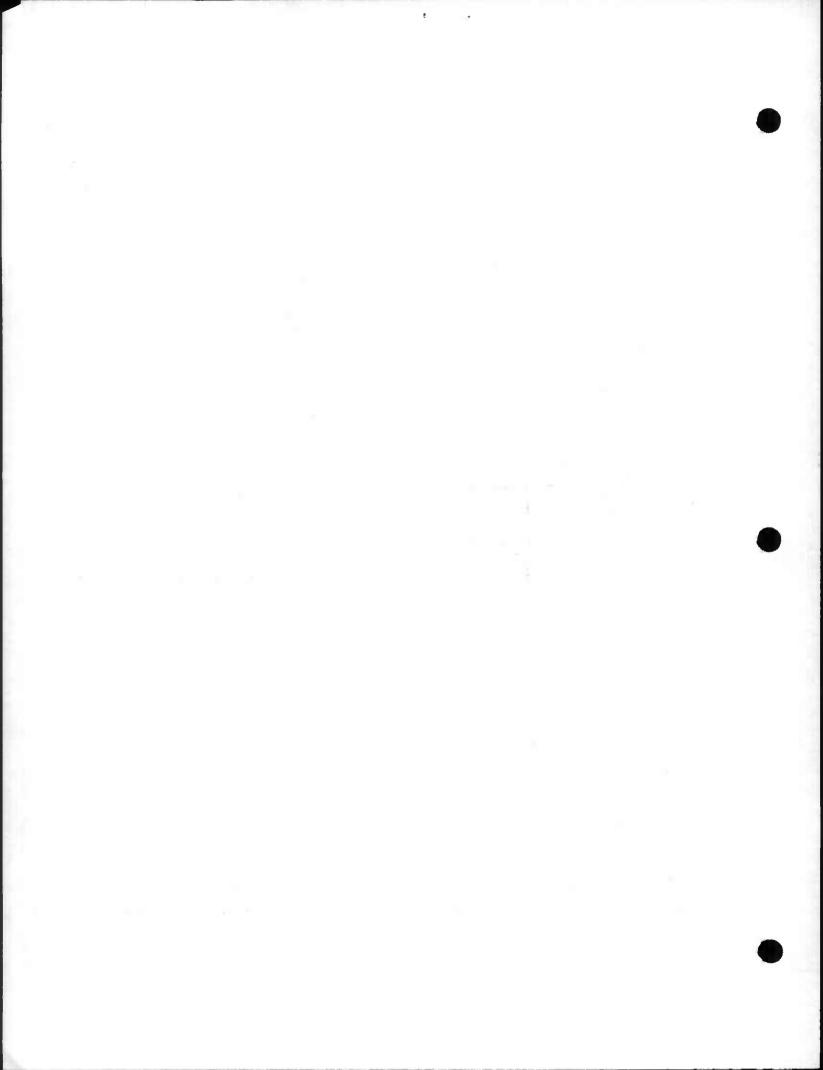
DHMH-16 Rev t/89

	1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE OF	DEATH		REG. NO.	_	
- 9	1. DECEDENT'S NAME (FIRST, MIDDIS, LIST)	Conte	0			2. DATE O	DAY DAY	YEAR 3.	TIME OF DEAT
- 0	4. 90GM SEQUETY MINUSER 6		in yrs. last birthday)	IF UNDER I YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH Day, Year)	B. BIRTHPLA Country)	ACE (State or Fo
1	214-18-8953	1 - M 2 F F	36 YRS.	MONTHS DAYS	HOURS MIN.		5-09	1.4	Iland
	De. FACILITY NAME (If not institution, give	street and number)		96. CITY, TOWN	OR LOCATION OF D	PEATH		NTY OF DEAT	5
05	RESIDENCE OF DECEDENT	lanor		Clinic	in ma	1201	35 Pri	nce (5	evige
DIRECTOR	10a. STATE 10b. COUNT	7	10c. CIT	Y, TOWN OR LOCA	TIDN			104	d. INSIDE CITY
	100. STREET AND NUMBER	nce George	He	MASCU	M. ZIP CODE		10a CITI	ZEN DF WHA	YES 2
ERA	23202 Nec	K Rd			20608		Tog. on	U,	3,
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES					(Specify Yea or No-	14. RACE — Black, W	American India
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			S 2 NO Speci		cent, etc.)	Specify:	Blace
	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUPATE work done during m	ION	16b.	KIND OF BUSINESS/IND	USTRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	ost or working			1.	
COMP	17. FATHER'S NAME (First, Middle, Lest)		Hon	nemaker	Las MOTUEDIO N	AME (5)	1 Jones	STIC	
E C	Joseph	Brow	6110		Alice	AME (I-IISI, M	iddle, Maiden Surname)	N. Lana	
00	19a. INFORMANT NAME (Type/Print)	10.00		ADDRESS (Street		Route Number	r. City or Town, State, Zio	Code)	
٩	Signey Cont	ee	15109	BAde	n llay	for 1	d Branch	, whe	M1):
	20s. SPIDD OF DISPOSITION 1 District 2 Cremation 3 Ran		ery, crematory of	OF DISPOSITION (Notice)	lame of	DATE	- 1	City or Town,	State
	4 Donation 6 Other (Specify)		hrist C		ND ADDRESS OF F	ACILITY	Mayaso	0 /	11) 2
	1 Trees	90		20605	- À	2		M	1) 20
- 11	resulting in death)	A	CONSEQUENCE						: 1 97 1/
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	CONSEQUENCE O	F):					
CAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. DUE TO (OR AS A DUE TO (OR AS A d.	CONSEQUENCE C	F):	ng ceuse given in		24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	CO	RE AUTOPSY FI ALABLE PRIOR MPLETION OF CO- DEATHS
MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A DUE TO (OR AS A d	CONSEQUENCE O	F):	ng ceuse given in		PERFORMED?	CO OF	ARLABLE PRIOR
AN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A DUE TO (OR AS A d	CONSEQUENCE O	F): In the underlyin			PERFORMED?	CO OF	ARABLE PRIOR MPLETION OF C DEATH?
SICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition	b. DUE TO (OR AS A DUE TO (OR AS A d	CONSEQUENCE CONSEQ	In the underlyle	LACE OF DEATH (C	heck only one	PERFORMED?	CO OF	ARABLE PRIOR MPLETION OF C DEATH?
SICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 TO 27. MANNER OP DEATH	b. DUE TO (OR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A DUE T	CONSEQUENCE CONSEQ	In the underlying 26. P		iheck only one	PERFORMED?	AW CO OF	ARABLE PRIOR MPLETION OF C DEATH?
SICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OP-DEATH 1 Natural 5 Pending investigation	b. DUE TO (OR AS A c. DUE TO (OR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A d. DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A d. DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A D. DUE	CONSEQUENCE CONSEQ	In the underlying 26. P OTHER: 4 Nursing Hor MURY W M 1	PLACE DF DEATH (C me 5	6 Other	PERFORMED? 1 YES 2 NO (Specify) PRIBE HOW INJURY OCC	AW CO OF 1 [NLABLE PRIOR MPLETION OF C DEATH? YES 2.21
ED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OP DEATH 1 Netural 5 Pending	b. DUE TO (OR AS A c. DUE TO (OR AS A d	CONSEQUENCE OF CONSEQ	In the underlying 26. P OTHER: 4 Nursing Hor MURY W M 1	PLACE DF DEATH (C me 5	theck only one 8 Other 28d. DESC	PERFORMED? 1 YES 2 NO	AW CO OF 1 [NLABLE PRIOR MPLETION OF OBEATH? YES 2-P
ETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OP DEATH 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	b. DUE TO (OR AS A c. DUE TO (OR AS A d	CONSEQUENCE OF CONSEQ	In the underlying 26. P OTHER: 4 Nursing Hor HE OF 28c. IN W M 1 1 street, factory, offk	PLACE DF DEATH (C me 5 Residence JURY AT ORK? YES 2 NO	6 Other 28d. DESC	PERFORMED? 1 YES 2 NO (Specify) RIBE HOW INJURY OCC TION (Street and Number Town, State)	OF 1 [NLABLE PRIOR MPLETION OF (DEATH) YES 2
OMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OP DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only	b. DUE TO (OR AS A c. DUE TO (OR AS A d	consequence of conseq	In the underlying 26. P OTHER: 4 Nursing Hor RE OF 28c. IN M I URY M street, factory, office the time, detime, detime, detime, detime, detime.	PLACE DF DEATH (C THE 5 Residence JURY AT ORK? YES 2 NO Ca a and place, and du	ineck only one 8 Other 28d. DESC 28t. LOCA City o	PERFORMED? 1 YES 2 NO (Specify) CRIBE HOW INJURY OCC TION (Street and Number Town, State)	OF OF Rural Route	NLABLE PRIOR MPLETION OF C DEATH? VES 2-21
E COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OP DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only	b. DUE TO (OR AS A c. DUE TO (OR AS A d	consequence of conseq	In the underlying 26. P OTHER: 4 Nursing Hor RE OF 28c. IN M I URY M street, factory, office the time, detime, detime, detime, detime, detime.	PLACE DF DEATH (C THE 5 Residence JURY AT ORK? YES 2 NO Ca a and place, and du	28t. LOCA City o	PERFORMED? 1 YES 2 NO (Specify) PRIBE HOW INJURY Occ TION (Street and Number rown, State) e(a) and manner as stated and place, and due to the	CURED Or Rural Route or Rural Route ed.	NLABLE PRIOR MPLETION OF C DEATH? VES 2-21
BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 700 27. MANNER OP DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 29b. SIGNATURE AND TILLE OF CERTIFIE	b. DUE TO (OR AS A c. DUE TO (OR AS A d	CONSEQUENCE CONSEQ	In the underlying 26. P 26. P OTHER: 4 Nursing Hor A C Nursing Hor A N	PLACE DF DEATH (C THE 5 Residence JURY AT ORK? YES 2 NO ce a and place, and du death occured at the	theck only one 6 Other 28d. DESC 28t. LOCA City of the cause time, data in	PERFORMED? 1 YES 2 NO (Specify) PRIBE HOW INJURY Occ TION (Street and Number rown, State) e(a) and manner as stated and place, and due to the	CURED Or Rural Route or Rural Route ed.	NABLE PRIOR MPLETION OF C DEATH? YES 2-21 Number,
E COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 700 27. MANNER OP DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 29b. SIGNATURE AND TILLE OF CERTIFIE	b. DUE TO (OR AS A c. DUE TO (OR AS A d	CONSEQUENCE CONSEQ	In the underlying 26. P 26. P OTHER: 4 Nursing Hor A C Nursing Hor A N	PLACE DF DEATH (C) THE 5 Residence JURY AT ORK? YES 2 NO Ca a and place, and du death occured at the	28t. LOCA City o	PERFORMED? 1 YES 2 NO (Specify) PRIBE HOW INJURY Occ TION (Street and Number rown, State) e(a) and manner as stated and place, and due to the	CURED Or Rural Route or Rural Route ed.	NAME PRIOR MPLETION OF DEATH? YES 2-8



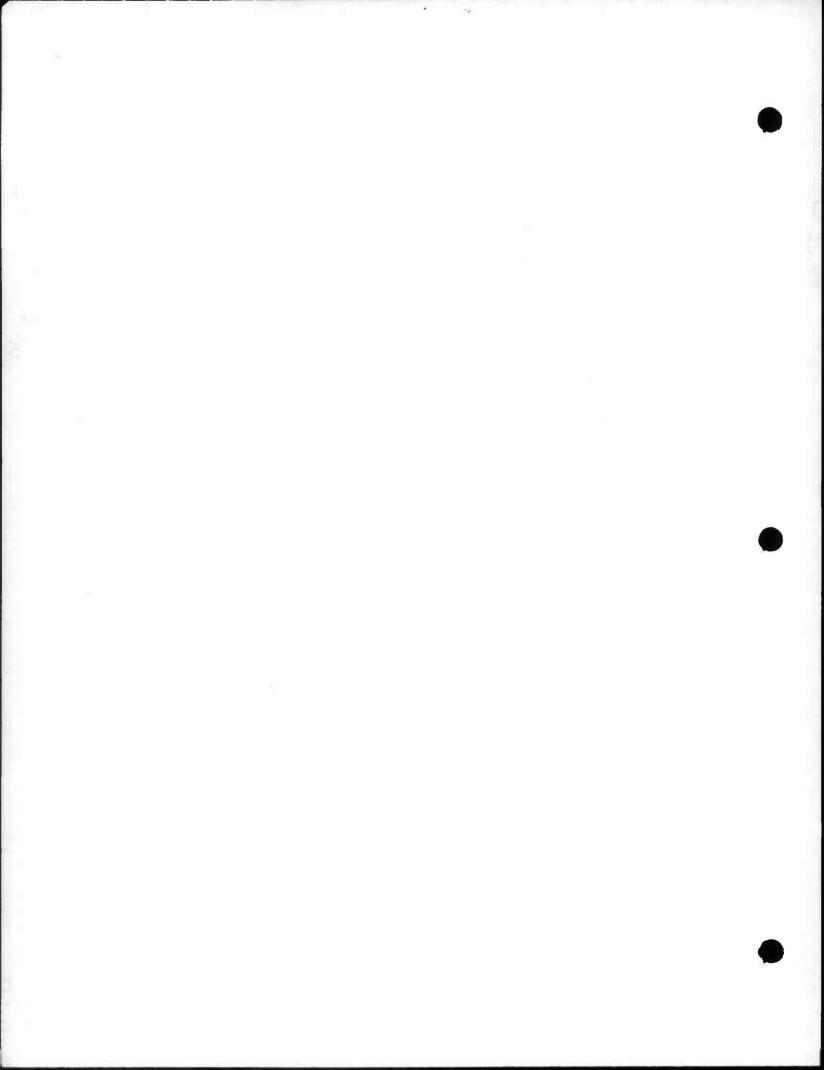
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	1 - STATE REGISTRAR	STATE OF MA					EALTH DEAT		MENTA	L HYGIEN REG. NO	_		
1	1. DECEDENT'S NAME (First, Middle, Last)					.1.			MONT	OF DEATN	Ay	YEAR	3. TIME OF DEATH
1	4. SOCIAL SECURITY NUMBER 5	SEX 6	AGE (In yrs. lest I	hirthrian)	IF UNDER	UTI	IF UNDER	24 MDC		ARCH OF BIRTH	7	95	IPLACE (State or Foreign
1 8	153-05-3104	□ M 2 🟋F	79	YRS.	MONTHS	DAYS	HOURS	MIN.	(Monti	h, Day, Year)	1015	Count	(y)
1	9a. FACILITY NAME (If not institution, give stree	t and number)			9b. CITY	, TOWN O	R LOCATIO	N OF DE		e 26,		NTY OF D	ew Jersey
E C	Suburban Hospital				Be	thes	đa						omery
ל	RESIDENCE OF DECEDENT 104. STATE 10b. COUNTY												
DIRECTOR		TOMORY.	İ		Y, TOWN O								10d. INSIDE CITY
	10e. STREET AND NUMBER	gomery			NOCK	-	ZIP CODE				10- 017	75N 05 N	1 YES 2 NO
ERA	1801 East Jefferson	Street				1 1011	2085					S.A	
FUNERAL		2. WAS DECEDENT E	VER IN U.S. ARM	ED	13.	WAS DEC	ENDENT OF	F HISPAN	IC ORIGIN	17 (Specify Yea		14 BACI	- American Indian
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TIF YES, GIVE WAR	OR DATES			If yes, spe		Specify		Rican, etc.)	1-1	Spec	white
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade coi	ION moletadi	16a. DECI	EDENT'S	USUAL O	CCUPATIO	N		16b	KIND OF BUS	SINESS/IND	USTRY	WIIICE
<u>-</u>		College (1-4 or 5+)	life. D	o NOT us	se retired.)	aunng mos	at of working	g					
MP	12		Bar	ique	t Ma	nage	r			Resta	uran	t	
	17. FATHER'S NAME (First, Middle, Last)									Middle, Malden	Surname)		
BE	John Fallon 19a. INFORMANT'S NAME (Type/Print)		404							ullin			
2	Mary Anne Salmon						Stre						nd 20815
	20a. METNOD OF DISPOSITION	.=0.00	20b. PLACE AN	DDATE	OF DISPOS				DAT	- 4	CATION -	4	
	1 Donation 5 Other (Specify)		Holy S	epu.	ther place)	e Cen	neter	У	3/6				Jersey
	21. SIGNATURE OF FUNERAL BETTYCE LICENSEE 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A.												
	- Grange of	9								Laure		d. :	20707
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Dp not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
PHYSICIAN: MEDICAL CE	DID TOBACCO USE CONTRIE	H YE	PER 1 TYES					24s. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
호		OSPITAL:	26. PLACE		N (Check								
¥.	1 YES 2 NO 1	Inpetient 2 - El		□ DOA 4 □ Nursing Nome 5 □ Rasidence 6 □ Other (Sp									
	1 Netural 5 Pending	(Month, Day,			URY	WOR	HC?	NO	28d. DE\$	CRIBE HOW IN	NJURY OCC	URED	
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined determined				M 1 YES 2 NO			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				loute Number,	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER: C												and manner as stated.
w	296. SIGNATURE AND TITLE OF CERTIFIER	1/100	C 00	1			29c. LICEN	ISE NUM	BER		29d. DATE	- 1	(Menth, Day, Year)
0 0	tance DF	1191	11/1	<u>"</u>			D 9	113	92)	3 3	195
	Parioa Selloga	ND	809 Ve	775	Print)	1	BS		Poc	EN/e	2	19	2085/
	MAR 0 7 1995	Julia day	SIGNATURE WHEN REND	all									



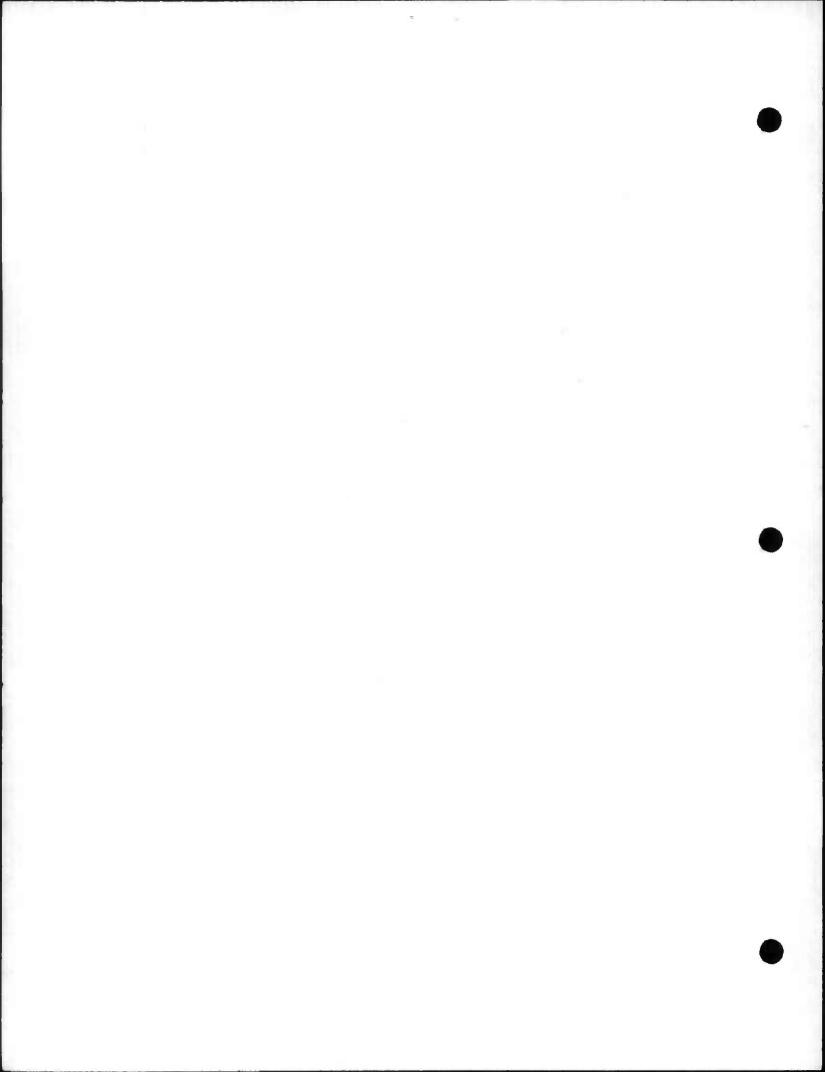
Amended #18, 3/10/95, D.D., Howard Co.

	1 - STATE REGISTRAR	STATE UP MAP	CERTIFI	CATE OF	DEATH AND	MENTAL HYGIE! REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last) MICHAEL	E.	COOK					EAR	ME OF DEATH			
	4. SOCIAL SECURITY NUMBER 215-23-5935	5. SEX 6. A	AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	MARCH 7. DATE OF BIRTH (Month, Day Year) NOV 29, 1		BIRTHPLACE	25 P. E (State or Foreign			
	9a. FACILITY NAME (If not institution, give at		ROAD	9b. CITY, TOWN (OR LOCATION OF D			Maryl	and			
CTOR	EAST BOUND RT.40	EAST OF MA	RRIOTSVILL	E ELI	JICOTT C	ITY	HOWA	RD COL	NTY			
DIRE	Maryland Ho	oward	l l	TOWN OR LOCAT				1	INSIDE CITY LIMITS? YES 2 X NO			
ERAL	100. STREET AND NUMBER 10778 Frederick F	Road		101	21042			N OF WHAT O				
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		DENT EVER IN U.S. ARMED 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. F. Puerto Rican, etc.) 14. Was decay, Puerto Rican, etc.)						nerican Indian, a, etc. White			
8	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S ((Give kind of w	ork done during mo		16b. KIND OF BU	SINESS/INDUS					
COMPLET	0=12	College (1-4 or 5+)	Landsc			Land	scapin	g				
BE CO	17. FATHER'S NAME (First, Middle, Last) Jonathan Cook				16. MOTHER'S NA	AME (First, Middle, Majdes inia Packe	Sumame)		-			
10	19a. INFORMANT'S NAME (Type/Print) Jonathan Cook		195. MAILING 10778	Freder:	ick Rd.,	Route Number, City or Tov Ellicott C	ity, M	d. 210	042			
11	20s. METHOD OF OISPOSITION 1 □ Burlel 2 □ Cremetion 3 □ Remo	ovel from State	206. PLACE AND DATE O	Bisposition (Na Washing	me of ton		urel,		ate			
	21. SIGNATURE OF FUNERAL SERVICE LIC	210	wner	HARRY			HOME		Fy 21043			
	23. PART I. Enter the diseases, or cahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause o	n aach iina.	ng inc		ch as cardiac or reap	iratory arres		Approximate Interval Between Onset and Death			
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST		AS A CONSEQUENCE OF									
: MEDICAL C	PART II. Other algorificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 10 F DEATH											
SICIAN:	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH YES		UNCERTAI	N 🗆		l				
I > I	EXAMINER? 1 X YES 2 NO 27. MANNER OF GEATH	HOSPITAL: 1 Inpatient 2 ER/	Outpatient 3 DOA			€XXOther (Specify)						
ВУ РН	1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJU (Month, Day, Ye 3 6 95	Found Found	9F 28c. INJ WO M 1 □ Y	URY AT RK? 'ES 2 K NO	hangin	5_					
	3 Suicide a Could not be 4 Homicide detarmined	28a. PLACE OF INJ building, atc. (URY — At home, farm, at Specify) Wood			281. LOCATION (Street City or Town, State)	R te 40	Rural Route No	umber,			
TO BE COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINES		nowledge, death occurred			to the cause(a) and ma		ausals) and n	nenner es stated			
TO BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER	uni I C	luste as		29c. LICENSE NU	MBER	29d. DATE S	GNED (Month	, Day, Year)			
Į Ė∥!	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) ■ MARCH 7, 1995											
		0			T BALTIN	MORE MARYL	AND 21	201				



DHMH-16 Ray 1/89

		1 - STATE REGISTRAR	SIAIE UF MART			F DEATH	MENTAL HYGIEN REG. NO						
		1. DECEDENT'S NAME (First, Middle, Lest)	CAtherine	Louis	se G	pates	2. DATE OF DEATH MONTH D.		S. TIME OF DEATH				
9		4. SOCIAL SECURITY NUMBER 212-74-9312	5. SEX 6. AGE	91 yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH NOV. 1, 19()3	BIRTHPLACE (State or Foreign Country) Maryland				
2, 3 should	OR	98. FACILITY NAME (If not institution, give St. Agnes Hosp				n on Location of C ltimore	DEATH	9c. COUNTY	OF DEATH				
t. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT Maryland How	w ward		TY, TOWN OR LO				10d. INSIDE CITY LIMITS? 1 YES 2 7 NO				
permit	1A	10e. STREET AND NUMBER			1	10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
an. ransit	FUNERAL	8621 Old Frederic				21043		U.	S.A.				
21215-0020 al or attending physician. for use as the burlai-transit	₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	S 27 NO	If yes,	DECENDENT OF HISPA , specify Cuben, Mexic YES 2 NO Spec	ANIC ORIGIN? (Specify Yes can, Puerto Rican, etc.) ifly:	or No- 14.	RACE — American Indian, Black, White, atc. Specify: White				
	COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	16a. DECEDENT'' (Give kind of life. Do NOT to HOUSE	work done during use retired.)	ATION most of working	16b. KIND OF BUS	SINESS/INDUS	TRY				
YLA by the	111 P	17. FATHER'S NAME (First, Middle, Last) Casper Kaiser					AME (First, Middle, Maiden Travis	Surname)					
40 00	2	198. INFORMANT'S NAME (NOMPTINE) Betty Walterhoele	pefek				Paule Number, City or Town		, Md. 21043				
FORE e 6 may rector, pa	must be	20a. METHOD OF DISPOSITION 1 ST Burlet 2 Cremetion 3 Rer 4 Donation 5 Other (Specify)	moval from Stata Ce	Ob. PLACE AND DATE ometery, crematory or IVY Hill	OF DISPOSITION other place)	(Name of	1	cation - city	or Town, Stata				
ALTIM death. Page funeral dire	examine	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE		22. NAME HARF	AND ADDRESS OF F	ACIUTY ZKE FUNERAL						
0 1		Muley	23 PART I Files the disease of complete the control of the control										
68760, B cecuted within 24 hours after and completely filled in by the burial, cremation, or removal	פאפחר, נוופ ווופטוכא	ahock, or heart stillure. IMMEDIATE CAUSE (Fine) disease or condition resulting in death)	a	gester	e Rea	ut fa		retory erreat	Approximate interval Between Onset and Death				
P.O. BOX th certificate be ex tending physician a il Hygiene prior to	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	DUE TO (OR AS	A CONSEQUENCE C	Б				5 ym				
DS, P the death the atten d Mental h		PART ii. Other algnificant condition	ns contributing to deeth	but not resulting	in the underly	ring ceuse given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS				
		Coronary					PERFOR 1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
law requast been bept. of		DID TOBACCO USE CONT	RIBUTE TO CAUSE O	OF DEATH Y	ES NO	☐ UNCERTAI	N D		1 TES 2 NO				
N: The la	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only of	ne)							
SICIAN: The State the State	5 ≥	1 YES 2 ONO 27. MANNER OF DEATH	1 Inpatient 2 ER/Out 28s. DATE OF INJURY		4 - Nursing H	ome 5 Residence		Lucy coore					
이 동 변호	Β .	1 Natural 5 Pending Investigation	(Month, Day, Year) 28s. PLACE OF INJUR	IN	JURY M 1	WORK? YES 2 NO	28d. OEŞCRIBE HOW II						
OR ATTENDING I	e iu	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Sp.	ecity)			281. LOCATION (Street a City or Town, State)		Rural Route Number,				
HOSPITAL O FUNERAL DI WITHIN 72 NO	= 5		ER: On the bast of my know						luse(s) and manner as stated.				
TO THE HOSPITAL TO THE FUNERAL De filed within 72	TO BE	296 SIGNATURE AND TITLE OF CERTIFIE	ie em	S. H	<u>D</u>	D45	MBER 530	29d. DATE SIG	GNED (Month, Day, Year) -8-95				
	1	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETEO CAUSE OF D		alon	Aue,	Balti	nior	1-21229				
10		31. DATE FILED (MONTH, Day, Year) MAR 1 0 1995	32. BEGISTRAR'S SIGN	NATURE Or Reveall					<i>)</i>				



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the clean of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTING			MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, La	Ther Car	1			2. DATE OF DEATH		YEAR	UE OF DEATH	
	4. SOCIAL SECURITY NUMBER					7. DATE OF BIRTH (Month, Day, Year)		. BIRTHPLACE	(State or Foreign	
	710-10-9414 9s. FACILITY NAME (If not institution, gi	1 M 2 F	79 YRS.	DAYS	R LOCATION OF D	Oct. 9,		Country) Ma	aryland	
TOR		eral Hospital			allston	CAIR		Harfo	rd	
DIRECTOR	10s, STATE 10b, COL		10c. CITY, T	TOWN OR LOCAT					INSIDE CITY LIMITS?	
	Maryland 100. STREET AND NUMBER	nartord		Bel A	ZIP CODE		I 100 CITIZE	1 🗆	YES 2 NO	
FUNERAL	2500 Fairway D	rive			210	15	log. Office	USA	JONNIN 7	
BY FUN	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yea, spe	NDENT OF HISPA city Cuban, Maxico NO Specifi	NIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	ea or No-	Black, White	nerican Indian, a, atc. Vhite	
COMPLETED	15. DECEDENT'S I (Specify only highest g Elementary/Secondary (0-12)	EDUCATION rade completed) College (1-4 or 5+)	16a. DECEOENT'S USI (Give kind of work life. Do NOT use re	k done during mos	N t of working	16b. KIND OF B	USINESS/INDUS			
NP.	Elementary/Secondary (U-12)	4	Electr:	ical En	gineer	U.S.	Govern	ment		
BE CO	17. FATHER'S NAME (First, Middle, Lest) George Walter	Carl			18. MOTHER'S NA	ME (First, Middle, Maide				
10 8	18s. INFORMANT'S NAME (TypusFront)	V	19b. MAILINO AD	DRESS (Street er	nd Number or Rural	Route Number, City or To	wn, State, Zip C	ode)		
	Helen 9/Carl	11/				Bel Air,			1015	
	29e. METHOD ON DEPOSITION 5/1 Burlet 2/1 Fremetion 3 R 4 Donatien Other (Specify)	lagioval from State can	PLACEAND DATE OF E netary, crematory or other LKWOOD CET	placal	na of	3/7 / 95	ocation – cit Balt			
	Parkwood Cemetery 3/7 / 95 Baltimore, Md. 22. NAME AND ADDRESS OF FACILITY HOWARD K. McComas III Funeral Home 1317 Cokesbury Road, Abingdon, Md 21009									
	23. PART I. Enter the distingen, shock, or heart failu iMMEDIATE CAUSE (Final disesse or condition resulting in deeth)	re. List Dnly Dne ceuse Dn e	d the deeth. Do not each line.	enter the mod	le of dying, suc	h aa cardiac or res	piratory erres	ıt,	Approximate intervsi Between Onset and Desth	
	DUE TO (OR AS A CONSEQUENCE OF):								1-2400	
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury cause of injury cause)									
ERTIF	that initiated events resulting in death) LAST d.									
PHYSICIAN: MEDICAL C	Partinsons Dizease. Performed? 1 yes 2 x no of 0								AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE EATH? YES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL	1								
2	EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:	CE OF DEATH (CA	8 Other (Specify)				
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJU	IRY AT	28d. DESCRIBE HOW	INJURY OCCU	RED		
À	1 Natural 5 Pending 2 Accident Investigation	n		M 1 🗆 Y	ES 2 NO					
E	3 Suicide S Could not be detarmined 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 28e. LOCATION (Street and Number or Rural Route Number City or Town, State)									
COMPLET		IYSICIAN: To the best of my know							menner as stated.	
100	29b. SIGNATURE AND VITLE OF CERTIF	FIER 1			29c. LICENSE NU	MBER	29d. DATE S	SIGNED (Monti	n, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON VIVEK	WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typo, Pri 2112 BE	int)	Road	Suite 5	F100.	tene 1	11 2/1/27	
	31. DATE FILED (Month, Day, Year) MAR 0 6 199	32. DEGISTRAR'S SIGN	ATURE OF RANGEL	April 4 4 4 Ear	- TONO)	, ,,,,	1000	7-10-1/	

ALTIMORE, MARYLAND 21215-0020 death. Page 6 may be retained by the hospital or attending physician. threats director name 5 should be detached for use as the hurstaness

BALT	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funera
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	PHY	this
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		1 - STATE REGISTRAR	STATE OF N	MARYLAI	ND / DEPAR Certif				MENTA	REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last)			DAVI				2. OATI	E OF DEATH	1995	/EAR 3.	TIME OF DEATH 23:590 M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In	yrs. last birthday) YRS.	IF UNDER t	YEAR IF UN	IDER 24 HRS.	7. DATE	of BIRTH	6	BIRTHPL/	ACE (State or Foreign
ponid		219-05-3093 9e. FACILITY NAME (If not institution, give	street and number)				TOWN OR LOC	ATION OF DE		-24-07	9c. COUNT	Y OF DEAT	MD.
, 20 20 20 20 20 20 20 20 20 20 20 20 20	TOR	ATLANTIC GE	ENERAL H	OSPI	TAL	BE	RLIN				Wor	CEST	ſ E R
ages 1,	DIRECTOR	10e. STATE 10b. COUNT	CESTER		10c. CIT	Y, TOWN OF	LOCATION					10	d. INSIDE CITY LIMITS?
ermit. r		10e. STREET AND NUMBER	, L 3 L \		1001	ANC	10f. ZIP C	ODE			10a. CITIZE		YES 2 NO
ransrt p	FUNERAL	109 , Somerse						1842	_		US		
use as the burial-transit permit. Pages 1, 2, 3 should	В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	2 NO	11	AS DECENDEN yes, specify C	uban, Mexice	n, Puerto	N? (Specify Yee Ricen, etc.)	or No 14	Bleck, W Specify:	American Indian, nite, etc.
nse as	TED	15. DECEOENT'S EDU (Specify only highest grad	e completed)		6e. DECEOENT'S (Give kind of life. Do NOT u	work done du	CUPATION ring most of we	orking	16	b. KINO OF BUS	INESS/INOUS	TRY	
o should be detached for notified at once.	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 -	+)	HOMEMA	,			0	wn Hoi	ME		
at once.	S	17. FATHER'S NAME (First, Middle, Last)								Middle, Malden	Sumame)		
notified a	B	RADCI IFF FVANS 190. INFORMANT'S NAME (Type/Print)	3	-	19b. MAILING	ADDRESS	Street and Nun	ARGI	E E	VANS	State Zin Co	orde)	
be noti	5	Preston Davis			109 8	OMER	SET S	ŜΤ.,	ОСЕ	AN CIT	ΓΥ, M	D.,	21842
must b		20e. METHOD OF DISPOSITION 1	oval from State	20b. Pt	Bry, cremetory or o	ther place)		FFDV	OAT		CATION — Cit		
caminer		21. SIGNATURE OF FUHERAL SERVICE LI			EVERGE		AME ANO ADD		CILITY		FRLIN	1 141	1.
oval.		John U.	the							L HOME		RLIN	v. Mp.
or rem		23. PART LEnter the diseases, or shock, or heart failure.	complications the List only one ceu	t causad ti	he deeth. Do r h line.	not entar t	he mode of	dylng, suci	h as car	diec or respir	ratory erres	t,	Approximata Interval Between
the and Mental Hygiene prior to burial, cremation, or removal, any injury, or other traumatic event, the medical examiner		IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	e.	Ca	onsequence of	ulm	oran	7	An	too			Onset and Death
ourial, c	N	Secured lathy the second lates C	b	(OII AS A C	W of	in t	ensio						
traums	CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING	OUE TO (OR AS A CONSEQUENCE OF):										
other	TIFIC	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST											
ental Hy			d		<u> </u>	eme	2 4	eye	,				
and Me	CAL	PART II. Other significant condition	ns contributing to	deeth but	not resulting	in the und	erlying caus	e given in	Part I.	24a. WAS AN / PERFORI		AVI	THE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE
State Dept. of Health Item 23 shows ar	MEDI									1 TYES 2	MO	OF	DEATH?
Dept. of	AN:	DID TOBACCO USE CONT	RIBUTE TO CA					CERTAIN	<u> </u>				
State C	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		PLACE OF DEA	OTHER:	ng Home 5	Residence	8 Oth	er (Snecity)			
after death with the 28 is marked, or	PH	27. MANNER OF DEATH 1 Natural 5 Pending	28e. OATE OF (Month, Di	INJURY	28b. TIM		Sc. INJURY AT WORK?			SCRIBE HOW IN	JURY OCCU	RED	
s marl	BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE O	F INJURY —	At home, ferm,	M street, tector	t YES	2 NO	28t. LO	CATION (Street a	nd Number or	Rural Route	Number.
rs after	ETED	4 Homicide determined	building,	etc. (Specify)	,					or Town, State)			
thin 72 hours	COMPLI		ER: On the beele of ea										d menner ee steted.
be filed within 72 h	O BE	29b. SIGNATURE AND TITLE OF CERTIFIE	F. W.	ter	o W	5	29c. I	ICENSE NUM	MBER 99	3	1 .	IGNEO (MO	onth, Day, Year)
	F	30. NAME AND ADDRESS OF PERSON WITH	no completed caus	SE OF DEATH	H (ITEM 27) (Type	Print)	phia	Ave	me	ے صو	ooin	Cts	uD,
	3	31. DATE FILEO (Month, Day, Year) EED 27 199	32. REGISTRA		URE - Parker	4.							

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

	1. DECEDENT'S NAME (First, Middle, Last,)					2. DATE	OF DEATH	N - 1	3. TIME OF DEAT
	Ralph Cresap D	avis						- 2	5 9	5 7:00 1
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last		NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.	. BIRTHPLACE (State or Fo
	220-16-4236	1 💢 M 2 🗆 F	79	YRS. MONT	HS DAYS	HOURS MIN.	Jan	1. 9 3 Hoar 9	16	"Maryland
	Sa. FACILITY NAME (If not institution, give	street and number)		9h (CITY TOWN	OR LOCATION OF		, , ,		Y OF DEATH
Œ	Washington Cour		- CI D	""						Washington
0	RESIDENCE OF DECEDENT	u	Hagerstown					wasningion		
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									
<u>c</u>			<i>d</i>	IOC. CITT, TOT						10d. INSIDE CITY
	Md.	Washing	120n		Sma	thsburg				1 TYES 2 TY
A	10e. STREET AND NUMBER	III. ZIP CODE							10g. CITIZE	N OF WHAT COUNTRY?
H	P.O. Box 215	21783								U.S.A
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.S. ARM				ANIC ORIGIN	7 (Specify Yes	or No 14	4. RACE — American India
	1 Never Married 2 Married	FORCES? 1	YES 2 NO)	If you, a	pecify Cuban, Mexi	can, Puerto	Rican, etc.)		Black, White, etc.
B	3 Widowed 4 Divorced	ww			1 🗆 🕇	S 2 X NO Spec	ony:			Specify: White
	15. DECEDENT'S ED			EDENT'S USUA	LOCCUPAT	ION	1 401	WHID OF THE		
	(Specify only highest grad	le completed)	(Give	e kind of work do Do NOT use retire	one durina m	ost of working	160	KIND OF BUS	INESS/INDUS	STHY
٦	Elementary/Secondary (0-12)	College (1-4 or 5+	.)	Atto				Law		
Σ				71.000	- Crt Cog					
COMPL	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Malden Surname)					
ш	Ralph O. Davis					Ai	rita	3. Cre	sap	
0	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Num							ber, City or Town	. State Zio Co	ode)
2	Emma Lou Davis		P	.O. Bo	x 215	5 Smiths	burg.	Md. 21	783	,
	20a, METHOD OF DISPOSITION									
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rer	moval from Stata	cemetery_crem	ID DATE OF DISI	POSITION (N	tame of	DAT	E 20c. LOC		y or Town, State
	4 Donation 5 Other (Specify)		Smeths			tory 2-20		Sm	unsou	vrg,Md.
	21. SIGNATURE OF FUNERAL SERVICE UCESTIES 22. NAME AND ADDRESS OF FACILITY Davis Funaral Homes 12525 Bradbury Ave.									
	Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783									
	23. PART i. Enter the diseeses, or							Smit	nsburg	, Ma. 21783
	iMMEDIATE CAUSE (Finei diseese or condition	. doute	- mu -	بار سا	1	1.7	tim			Onset and
- 1	resulting in death)	DUE TO (OR AS A CONSEQU	JENCE OF):	1	Time				4 day
NOI	ordering her conditions,	DUE TO (OR AS A CONSECU	JENCE OF): JENCE OF):	hea	I de	neire	~		years
CATION	If sny, lasding to immediata cause. Enter UNDERLYING	b. ater DUE TO (OR AS A CONSEOU	JENCE OF): JENCE OF):	hea	I de	nore	·		years Vear
IFICATION	If sny, lasding to immediate	a ather	OR AS A CONSCOU	JENCE OF):	hea	I de	nor			year year
RTIFICATION	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury	a ather	or as a consecu	JENCE OF):	hea	I de	nore			year year
CERTIFICATION	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events	a ather	or as a consecu	JENCE OF):	hea	I de	nore			year year
	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events	c. ather DUE TO (OR AS A CONSEOU	JENCE OF):				24s. WAS AN /		years Year 24b. WERE AUTOPSY FII
	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST	c. ather DUE TO (OR AS A CONSEOU	JENCE OF):				24e. WAS AN A	MED?	Years Years Years 24b. WERE AUTOPSY FII AMAILABLE PRIOR I COMPLETION OF C
EDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST	c. ather DUE TO (OR AS A CONSEOU	JENCE OF):				24s. WAS AN /	MED?	AMAILABLE PRIOR 1 COMPLETION DF C OF DEATH?
MEDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition	c. DUE TO (OR AS A CONSEQU	JENCE OF): JENCE OF): Builting in the	underiyin	ng Couse given l	n Part i.	24e. WAS AN A	MED?	AVAILABLE PRIOR 1
MEDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition	c. DUE TO (OR AS A CONSEQUENCE OF DEATI	HENCE OF): JENCE OF): Duiting in the	underiyin	ng couse given le	n Part i.	24e. WAS AN A	MED?	AMAILABLE PRIOR 1 COMPLETION DF C OF DEATH?
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SICIAN: MEDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT	DUE TO (OR AS A CONSEQUENCE OF DEATI	ENCE OF): ENCE OF): Puiting in the H YES OF DEATN (Che	underlyin NO [seck only one)	UNCERTA	n Part i.	24s. WAS AN PERFORI 1 YES 2	MED?	AMAILABLE PRIOR 1 COMPLETION DF C OF DEATH?
SICIAN: MEDICAL	if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (DUE TO (DUE TO (d. RIBUTE TO CAL HOSPITAL: 110 Inputtent 2 □ 28a. DATE OF I	OR AS A CONSEOU OR AS A CONSEOU death but not ree USE OF DEATI 26. PLAGE ER/Outpatient 3 [INJURY]	H YES OF DEATH (Che	Underlyin NO [seck only one) HER: Nursing Non 28c. IN.	UNCERTA UNCERTA UNCERTA	N Othe	24e. WAS AN / PERFORI 1 YES 2	MED?	AMALABLE PRIOR COMPLETION DF C OF DEATH? 1 YES 2 N
PHYSICIAN: MEDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATN 1 Neturel 5 Pending	DUE TO (DUE TO	OR AS A CONSEOU OR AS A CONSEOU death but not ree USE OF DEATI 26. PLAGE ER/Outpatient 3 [INJURY]	ENCE OF): BUILDING IN THE BUILDING IN THE OF DEATN (Che OTH DOA OTH 4 1	Underlyin NO [pok only one) IER: Nursing Non 28c. IN.	UNCERTA UNCERTA December 5 - Residence JURY AT DRK?	N Othe	24s. WAS AN PERFORI 1 YES 2	MED?	AMALABLE PRIOR COMPLETION DF C OF DEATH? 1 YES 2 N
BY PHYSICIAN: MEDICAL	if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER O DEATN 1 Netural 5 Pending Investigation	DUE TO (1) DUE TO	OR AS A CONSEOU OR AS A CONSEOU death but not rec USE OF DEATI 26. PLACE ER/Outpatient 3	H YES OF DEATH (Che DOA OTH DOA 4 1 1 DOA MINJERY M	Underlyin NO [seck only one) IER: Nursing Non 28c. IN. 1 [UNCERTA UNCERTA Description of the second	IN Othe	24e. WAS AN / PERFORI 1 YES 2	MED?	AMAILABLE PRIOR COMPLETION DF C OF DEATH? 1 YES 2 N
D BY PHYSICIAN: MEDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1	DUE TO (DUE TO	OR AS A CONSEOU OR AS A CONSEOU death but not ree USE OF DEATI 26. PLAGE ER/Outpatient 3 [INJURY]	H YES OF DEATH (Che DOA OTH DOA 4 1 1 DOA MINJERY M	Underlyin NO [seck only one) IER: Nursing Non 28c. IN. 1 [UNCERTA UNCERTA Description of the second	IN S Other	24e. WAS AN / PERFORI 1 YES 2	MED?	AMALABLE PRIOR COMPLETION DF C OF DEATH? 1 YES 2 N
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COMPLETED BY PHYSICIAN: MEDICAL	If sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OP DEATN 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29a. CERTIFIER (Check only) CERTIFYING PNYS	DUE TO (DUE TO (DUE TO (d. TRIBUTE TO CAU HOSPITAL: 11 Inpettent 2 28a. DATE OF I (Month, Da) 28b. PLACE OF building, e	OR AS A CONSEQUENCE OF DEATI 26. PLACE ER/Outpatient 3 INJURY 1987 FINJURY — Al home sic. (Specify)	H YES OF DEATH (Che DOA 4 DOA 4 DOA 4 DOA 6 TIME OF INJURY)	Underlyin NO Esck only one, IER: Nursing Non 1	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA NO DRIVER YES 2 NO DRIVER B and place, and du	8 Other 28d. DES	24a. WAS AN I PERFORI 1 YES 2 (Specify) CRIBE NOW IN ATION (Street as or Town, State)	MED? NO NO NO NUMBER OF I	AMAILABLE PRIOR COMPLETION DF COP DEATH? 1 YES 2 N N RED Rural Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER OF DEATN 1 Naturel 5 Pending Investigation Accident Suicide B Could not be distermined 298. CERTIFIER (Check only one) MEDICAL EXAMINERY	DUE TO (DUE TO (DUE TO (d. TRIBUTE TO CAU HOSPITAL: 11 Inpettent 2 28a. DATE OF I (Month, Da) 28b. PLACE OF building, e	OR AS A CONSEQUENCE OF DEATI 26. PLACE ER/Outpatient 3 INJURY 1987 FINJURY — Al home sic. (Specify)	H YES OF DEATH (Che DOA 4 DOA 4 DOA 4 DOA 6 TIME OF INJURY)	Underlyin NO Esck only one, IER: Nursing Non 1	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA	8 Other 28d. DES	24a. WAS AN I PERFORI 1 YES 2 (Specify) CRIBE NOW IN ATION (Street as or Town, State)	MED? NO NO NO NUMBER OF I	AMAILABLE PRIOR COMPLETION DF COP DEATH? 1 YES 2 N RED Rural Route Number,
D BY PHYSICIAN: M	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (DUE TO (DUE TO (d. TRIBUTE TO CAU HOSPITAL: 11 Inpettent 2 28a. DATE OF I (Month, Da) 28b. PLACE OF building, e	OR AS A CONSEOU OR AS A CONSEOU death but not ree USE OF DEATI 26. PLACE ER/Outpatient 3 [INJURY y, 'lear') FINJURY—Al home of the constant of the const	H YES DOAN OTH DOA OTH	Underlyin NO Eschooly one) EER: Nursing Nor 28c. IN, 1	UNCERTA Description UNCERTA Description	8 Othe 281. LOC City to the cau a lime, data	24a. WAS AN I PERFORI 1 YES 2 I (Specify) CRIBE NOW IN ATION (Street as or Town, State)	MED? NO NO NO NO NO NO NO NO NO N	AMAILABLE PRIOR COMPLETION DE COOPLETION DE COOPLETION DE COOPLETION DE COOPLETION DE COOPLETION DE COMPLICION DE COMPLETION DE COMPLETION DE COMPLETION DE COMPLETION DE
BE COMPLETED BY PHYSICIAN: MEDICAL	if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (DUE TO (DUE TO (d. TRIBUTE TO CAL HOSPITAL: 11 Inputent 2 28a. DATE OF I (Month, Da) 28a. PLACE OF building, e	OR AS A CONSEOU OR AS A CONSEOU death but not ree USE OF DEATI 26. PLACE ER/Outpatient 3 [INJURY y, 'lear') FINJURY—Al home of the constant of the const	H YES DOAN OTH DOA OTH	Underlyin NO Eschooly one) EER: Nursing Nor 28c. IN, 1	UNCERTA Description UNCERTA Description	8 Othe 281. LOC City to the cau a lime, data	24a. WAS AN I PERFORI 1 YES 2 I (Specify) CRIBE NOW IN ATION (Street as or Town, State)	MED? NO NO NO NO NO NO NO NO NO N	AMAILABLE PRIOR COMPLETION DF COP DEATH? 1 YES 2 N RED Rural Route Number,

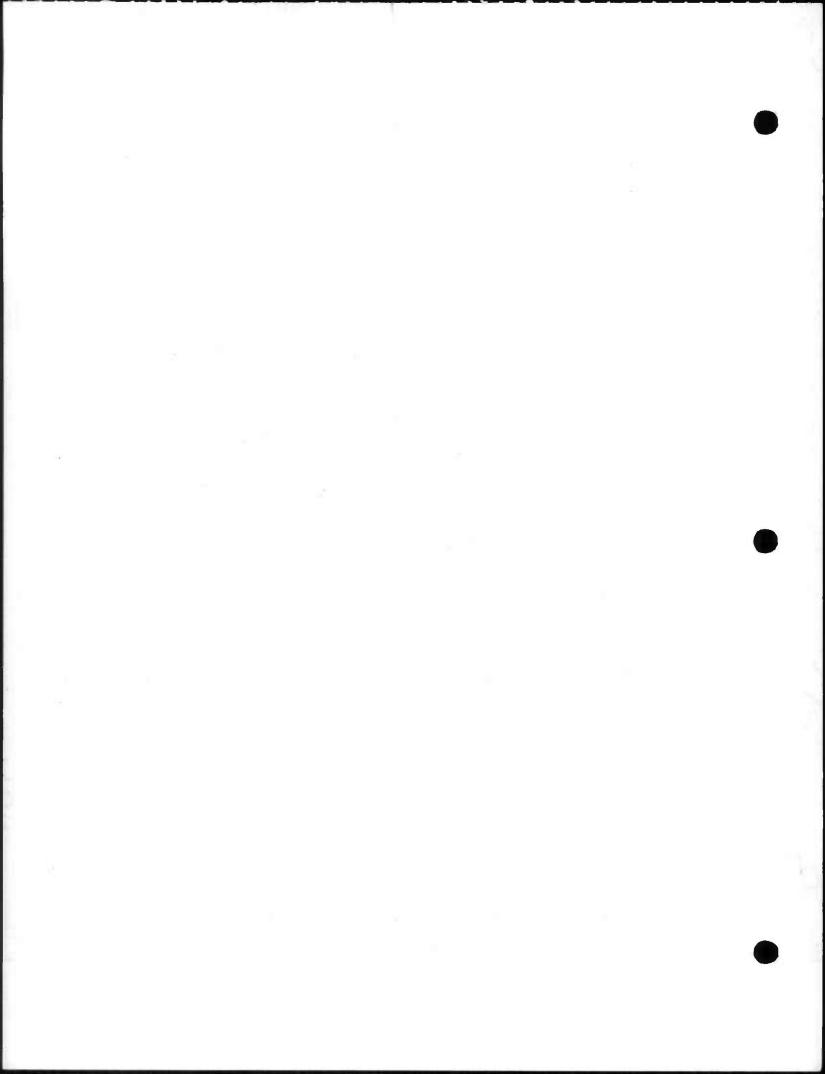
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DIVISION OF VITAL RECORDS, P.O. B

s after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1.2.3 should	emoval.	dical examiner must be notified at once.	
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rouns after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in I	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

,	REGISTRAR				CERTIF	ICATE (OF DEATH	- A	EG. NO.				
	1. DECEDENT'S NAME (First,							2. DATE OF				3. TIME OF DEATH	
	EHE	tta Lo	rena	De	nton			Februar	y 21,	" 1995	YEAR	11 A	
1 1	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yo	s. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF E	BIRTH			HPLACE (State or Foreign	
	218 32 5213		1 M 2 F	87	YRS.	MONTHS DA	78 HOURS MIN.	July 25	y, Year)		Count	yland	
	9e. FACILITY NAME (If not in:			- 07		9b. CITY, TOWN OR LOCATION OF DEATH						-	
L								EATH			NTY OF DEATH		
일	8201 Broomes Island Road					Broomes Island Calvert							
E C	10e. STATE 10b. COUNTY					Y, TOWN OR LO	CATION					10d. INSIDE CITY	
DIRECTOR	Maryland	Calvert			Dm	Broones Island R						LIMITS?	
	10e. STREET AND NUMBER	CHIVELL			I IIIC	101. ZIP CODE			40- CIT	1 TES 2 NO			
FUNERAL	8201 Broomes Island Road					20615			UNib	10g. CITIZEN OF WHAT COUNTRY? UNited States			
빌	11. MARITAL STATUS		In the December										
	1 Never Merried 2		FORCES? 1	YES 2	NO	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes If yes, specify Cuben, Mexican, Puerto Rican, etc.)					14. RACI Blac	E — Americen Indien, k, White, etc.	
Ma	3. Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: White												
	- 11	EDENT'S EDUCA	TION	164	DECEDENT'S	IIBLIAL OCCU	ATION	405 800	0.00.0110				
	(Specify only highest grade completed) (Give				(Give kind of a	vork done during	most of working	19D. KIN	D OF BUS	INESS/INE	DUSTRY		
2	Elementary/Secondary (0-	-12)	College (1-4 or 5+	' (owner gr			ret	ail s	ales			
COMPLETED	17. FATHER'S NAME (First, MI	elette de est					_			_			
8	Charles Edward						18. MOTHER'S NA Mary All	ME (First, Middle	e, Maiden :	Surname)			
H													
임	190. INFORMANT'S NAME (7) Mary Louise Hu				19b. MAILING	ADDRESS (Str	Rd. Broomes	Route Number, C	ity or Town	State, Zip	Code)		
-	-		<u> </u>						утагы	2001.			
	20s. METHOD OF DISPOSITI	ON n 3 □ Remova	al from State	20b. PL./	ACE AND DATE	OF DISPOSITION	Markebruary2	4 1995	20c. LOC	CATION —	City or To	own, State	
	4 Donetion 5 Other	(Specify)		Broa	mes Isla						mes Is. Cal. Maryland		
	21. SIGNATURE OF FUNERAL	SERVICE LICEN	SEE				E AND ADDRESS OF FA	CILITY					
	100	11.00				4405	Broomes Is.	Bri Bay	sch F	unera	Han	e Tami	
\vdash	23. PART I. Enter the di	BARRAR DE COL	molications that	coursed the	a death De -								
	ahock, or he	art fellure. Lie	at only one cau	ne Dn each	line.	ot enter the	mode or dying, suc	n aa cardiac	or reapi	atory ari	reat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Attrosclubition leasth												
	DUE TO (OR AS A CONSEQUENCE OF):												
NO	Sequentially list condition	ons. b.											
CERTIFICATION	if any, leading to immed cause. Enter UNDERLYII	late	DUE 10 (OR AS A CO	NSEOUENCE OI	7):							
일	CAUSE (Disease or Injui		DUE TO	00.10.1.00									
	that initiated events resulting in death) LAST		DOE 10 (OH AS A COP	NSEOUENCE OF	-):						i	
#		d											
	PART II. Other significan	nt conditions	contributing to	death but n	Dt reaulting	n the under	ving cause given in	Part I 24s	. WAS AN	MITTOREY	245	. WERE AUTOPSY FINDINGS	
EDICAL	the						certfail		PERFOR	WED?	240	AVAILABLE PRIOR TO	
		10 -17 -	3777	Caro	1)01	70	en 1-01	10	YES 2	I NO		COMPLETION OF CAUSE OF DEATH?	
Σ								_				1 TES 2 LNO	
ž	DID TOBACCO US		BUTE TO CAI	JSE OF D	EATH YE	S NO	☐ UNCERTAIL	V 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?		IOSPITAL:	26. F	PLACE OF DEAT		ne)						
YSI	1 TES 2 HO		☐ Inpatient 2 ☐	ER/Outpatien	nt 3 🗆 DOA	OTHER:	iome 5 Reeldence	6 Other (Spi	ecify)				
Ŧ	27. MANNER OF DEATH		26e. DATE OF (Month, Da		26b. TIM	E OF 28c.	INJURY AT WORK?	26d. DESCRIE	BE HOW IN	JURY OC	CURED		
BY		Pending Iveatigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			YES 2 NO						
	3 Suicide 6 0	Could not be	26e. PLACE OF	INJURY — A	it home, farm, a	treet, lectory, o	ffice	26t. LOCATION	N (Street a	nd Number	or Rural F	Route Number,	
		etermined	building, 4	nc. (Specify)				City or Tou	wn, State)				
٣ ا	290. CERTIFIER 1 LCERTI	EVING PHYSICIA	N: To the best of	m. kaandadaa	doub accord	4 -4 45 - 41	nessimulti tellira	TOTAL 1500					
COMPLETED							late end piece, end due					e) end menner es atated.	
8					201 Intreatigatio	n, in my opinio	n, death occured at the	time, date end	piace, enc	due to th	e ceuse(e	e) end menner es stated.	
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER			^		29c. LICENSE NUM			29d. DAT	E SIGNED	(Month, Day, Year)	
0		~	matt	The	m)		19-25	435		1	2/7	2755	
- 1	30. NAME AND ADDRESS OF	PERSON WHD	COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type,	Print)							
	Mukesh M	iathur, M	D 135 West	Dares	Beach F	d. Prin	æ Frederick	MD 2067	8				
I	31. DATE FILED (Month, Day, Y	bar)	32 REGISTRAF	S SIGNATUE	E								
	FEB 23	1995	Julia Dan	ucleus - Re	ardall								



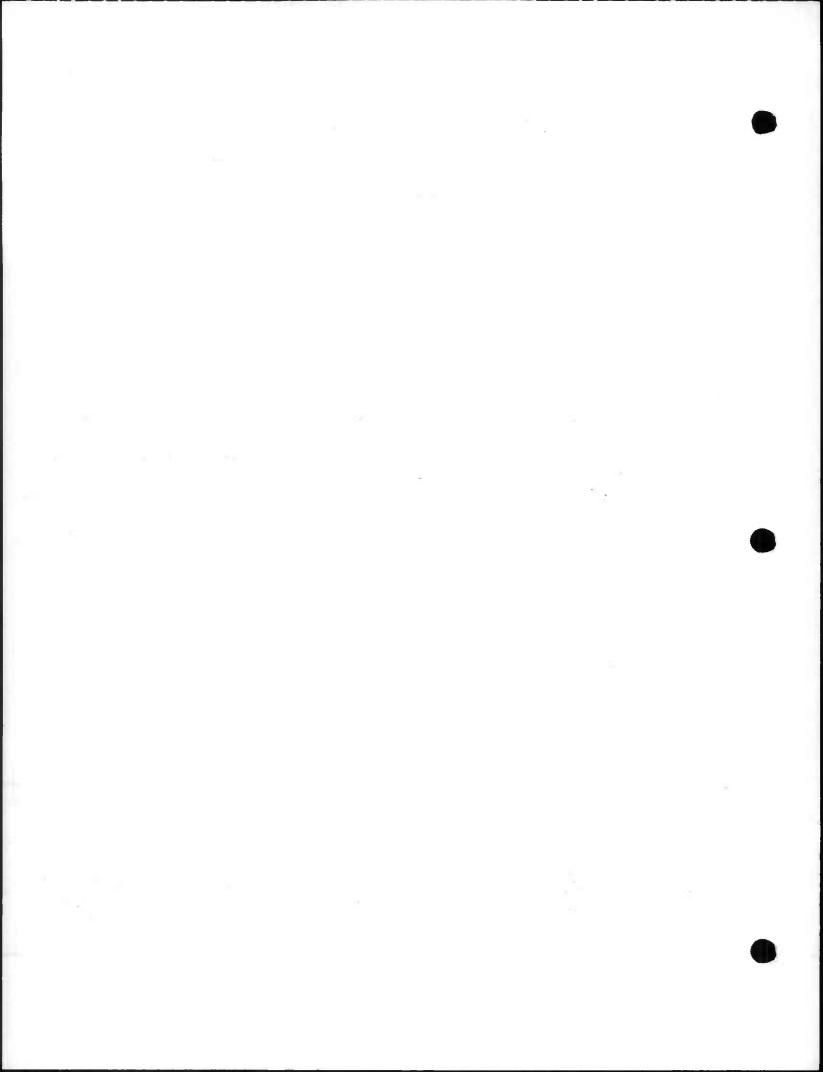
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Abours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	С	ERTIFICATE	OF DEAT	ГН		BEG NO

	FOR STATE REGISTRAR	STATE OF MARYLAND	D / DEPARTM	ENT OF H	EALTH AND	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	GILBERT C.		DISHA	ROON	2. DATE OF DEATH DAY FEBRUAR	YEAR -Y 24, 199	3. TIME OF DEATH	
2000	4. SOCIAL SECURITY NUMBER 215-20-0314	5. SEX 6. AGE (In yrs. 1 X M 2 \square F 78	YRS. IF	UNDER 1 YEAR ITHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Mogth, Day, Year) 2-27-1	6 BID	THPLACE (State or Foreign MARYLAND	
TOR	99. FACILITY NAME (If not institution, give PENINSULA REGION RESIDENCE OF DECEDENT				SBURY	BE. COUNTY OF DEATH WICOMICO			
DIRECTOR		SUSSEX		ILLSB			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL		SEYS LANDING		101	2IP CODE 19966	5	10g. CITIZEN OF WHAT COUNTRY? U • S • A •		
è l	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	ARMED	If yes, spe	ENDENT OF HISPAN Inclination of the control of the	IIC ORIGIN? (Specify Yes on, Puerto Rican, etc.)	Bla	CE — American Indian, ck, White, etc.		
PLETED	15. DECEDENT'S EDI (Specify only highest grad Elementery/Secondary (0-12) 1 2	DECEDENT'S USU (Give kind of work of life. Do NOT use reti TEACH	done during mo: ired.)	N st of working	166. KIND OF BUSI		700		
E COMPL	17. FATHER'S NAME (First, Middle, Last) LEE DISHA	TEACH	EK		ME (First, Middle, Maiden S		OOL		
10	19e. INFORMANT'S NAME (Type/Print) VIRGIE N. DI	SHAROON				Route Number, City or Town, LANDING, M.		RO, DEL.	
20e. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) PITTSVILLE CEMETERY 22c. NAME AND ADDRESS OF FACILITY									
4	22 PAST I. Enter the diffeases, or	Smull	5	ВО	UNDS FU	INERAL HOI	ME, SAL	ISBURY, MD.	
4	immediate Cause (Finel disease or condition resulting in death)	a	lina.		Our		itory arrest,	Approximate interval Batween Onset and Death MONTHS	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d								
MEDICAL	PART II. Other significent condition Roley dra	tion C	ande	er l	retasi	YES 2)	IED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
HYSICIAN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 AO		LACE OF DEATH (C	HER:					
ву Рну	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJU	IRY AT	6 Other (Specify) 26d. DESCRIBE HOW IN.	JURY OCCURED		
3	3 Suicide S Could not be determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, street	, factory, office		28f. LOCATION (Street and City or Town, State)	d Number or Rurel	Floute Number,	
COMPLE	2 MEDICAL EXAMINI	ICIAN: To the best of my knowledge, ER: On the beels of examination end/	death occurred at for investigation, in	the time, date	end place, end due eth occured at the	to the cause(s) end mann time, date end piece, end	er es stated. due to the ceuse	(s) end menner es stated.	
	29h. SIGNAZUITE AND TITLE OF CERTIFIE	· Nes	7		29c. LICENSE NUN	18ER	DATE SIGNE	0 (Morrin, Day, Wast)	
-	W. L. M. El	OCOMPLETED CAUSE OF DEATH I	æ	105	Viske	ing the	LR5	31501	
0	FEB 2 7 1995	32 AEGISTRAR'S SIGNATUR	ardally			0			



1995

9c. COUNTY OF DEATH

USA

Liberty Town, MD

WICOMICO

10g. CITIZEN OF WHAT COUNTRY?

Specify:

White

16

3. TIME OF DEATH

0619

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

1 YES 2 X NO

Approximata

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 [] YES 2 [] NO

29d. DATE SIGNED (Month, Day, Year)

106 PINE BLUFF RD GUTE12

Interval Between

Onset and Death

ylan

8. BIRTHPLACE (State or Foreign Country)

Maryland

2. DATE OF DEATH

February

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

EARL

30, NAME AND AGE

31. DATE FILES (Month, Day, Year) FEB 21 1995

4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthdev) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS MIN. 214-12-5662 1 M 2 D F 80 YRS April 5, 1914 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT IOc. CITY, TOWN OR LOCATION Maryland Wicomico Willards permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit abufal, cremation, or removal. 35989 Purnell Crossing Rd. 21874 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Marken, Puerto Rican, etc.)
1 YES 2X NO Specify: 1 Never Married 2 Married B 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 9 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) ᆸ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8 Grower Poultry once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sums notified at Goldsbrough Dennis Martha Elizabeth Clark BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lillie B. Dennis P.O. Box 48, Powellville, MD 21852 pe 20a. METHOD OF DISPOSITION
1 M Burlel 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of must OATE 20c. LOCATION - City or Town, State 4 Donation 8 Other (Specify) Oak Hall Riverside Cemetery medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 23. PART I Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart fellure. List only one cause on each li IMMEDIATE CAUSE (Final the or condition arterioselejoja Gardiovariula Premi. event, reaulting in death) executed within DUE TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION Sequentially list conditions, the attending physician a Mental Hygiene prior to DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 50 any injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part 1. MEDICAL 24a. WAS AN AUTOPSY signed by the Mobilen 1 | YES 2 | NO Shows ? bept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: s certificate ha th the State Di d, or Nem 2 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The **EXAMINER?** HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1 YES 2 -NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) . this c 28b. TIME OF 28c. INJURY AT WORK? 28d, OESCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED . 28 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: If Item 2 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND STILE OF CERTIFIER 29c. LICENSE NUMBER BE 140 2

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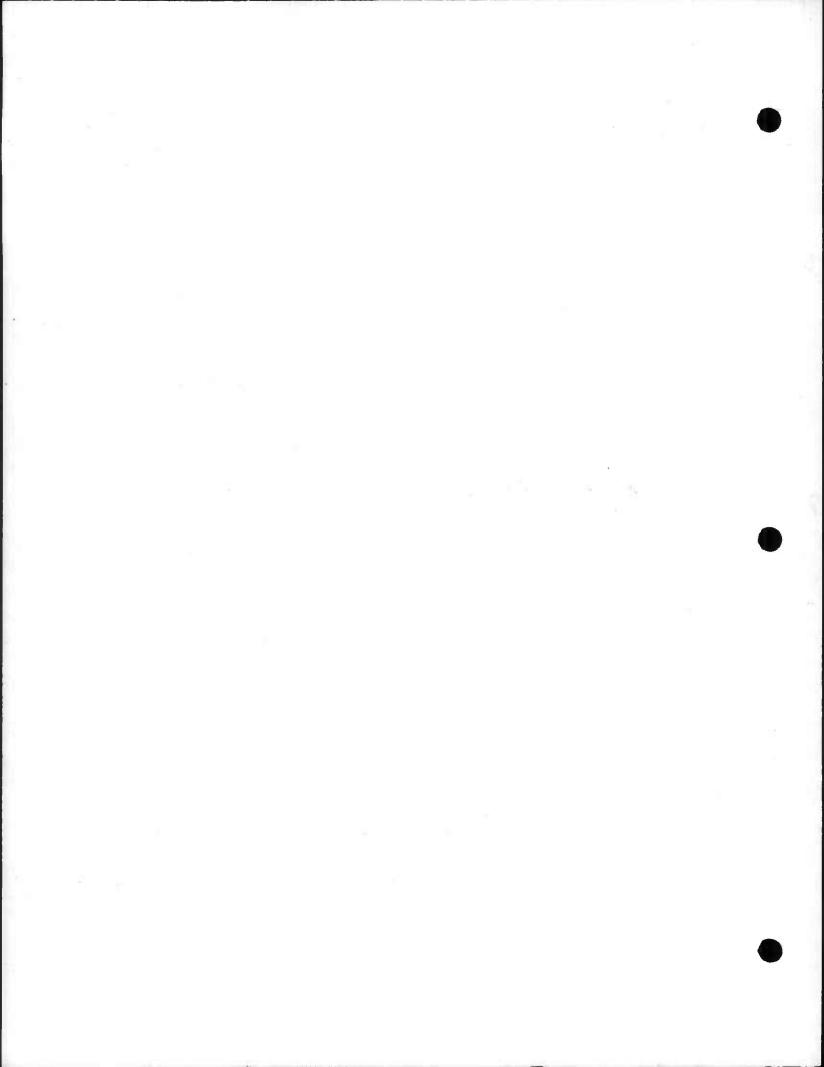
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32 REGISTRAN'S SIGNATURE

VINCENT

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH February 28,1995 Elizabeth Parks Dye Tobitha 1:15 a. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign 579-38-8235 1 🗆 M 2 😾 89 YAS. Nov 1905 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Mary's Hospital St. Mary's Leonardtown RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Charles Newburg 1 YES 2 W NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 13393 Beach Haven Circle be detached for use as the burial-transit 20664 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES STAND IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 84 3X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complet 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Isom Parks Ħ BE Mollie Byrd Parks notified funeral director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Leatrice H. Yates 13393 Beach Haven Cir 2 Newburg MD 2066/ å 20a. METHOD OF DISPOSITION

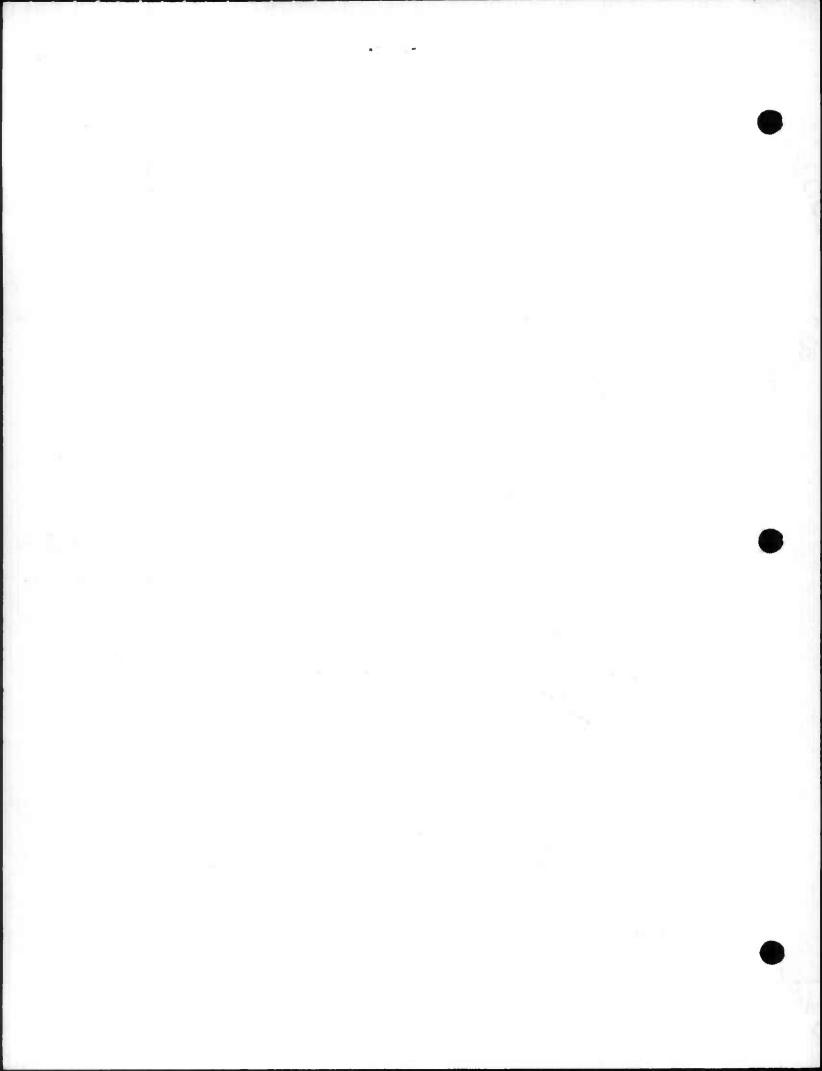
(※ Burlel 2 □ Cremation 3 □ Ramoval from State Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must woodlawn Mem. Bluefield, W VA. 4 Donation 5 Other (Specify) Park 3/4/95 examiner 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE hours after death. F ed in by the funeral or removal. AREHART-ECHOLS FUNERAL HOME, INC. MO0945 Daviel 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical completely filled in by shock, or heart failure. List only one cause on each line. Onset and Des IMMEDIATE CAUSE (Final the disease or condition w resulting in death) traumatic event. DUE TO JOR AS A CAR attending physician and corntal Hygiene prior to burial, 1 ne CERTIFICATION Sequentially list conditions, if any, leading to immediate BUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO JOR AS A CONSEQUENCE OF that initiated events resulting in death) LAST 0 the attent injury. PART II. Other significant conditions contributing to death but not resulti MEDICAL PERFORMED? WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO Health and N shows any COMPLETION OF CAUSE QCI 1 YES 2 NO t, of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only or Item . certificate h **EXAMINER?** HOSPITAL: OTHER 1 YES 1 A me S 🖾 Residence 8 🗆 Other (Specify) the 6 27. MANNER OF DEATH 28s. DATE OF INJURY this c JIIb. TIME OF INJURY 28c. INJUNY AT WORK? 284. DESCRIBE HOW INJURY OCCURED Is marked, 1 Matural 2 Accident M 1 YES 2 NO After the BY 25e. PLACE OF BUURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 281. LOCATION (Street and Number in Ferral Floute Number Officer Town, State) DIRECTOR: /
hours after d
item 28 Is COMPLETED 4 | Homicide 29a. CERTIFIER-CERTIFYING PHYSICIAN: To the best of my data and place, and due to the cause(s) and manner as stated. 3 MEDICAL EXAMINER 296. SIGNATURE AND TITLE OF DESTRIFIES BE 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Leonardtown, Maryland 20650

M.D.

alia d'audior Res

Dr. David M. Federle,



funeral director, page 5 should be detached for use as the burial-transit ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should

permit.

filled in by the and completely for burial, cremation the attending physician a Mental Hygiene prior to signed by t Health and been s HOSPITAL OR ATTENDING PHYSICIAN: The law has be Dept. this certificate h DIRECTOR: After the hours after death vitem 28 is mark

29b. SIGNATURE AND

31. DATE FILED (Month, Day, Year)

Shrestha

APLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. M. Shrestha; P.O. Box 2018; Salisbury, Md. 21802 32 REGISTRAR'S SIGNATURE
Julia Howline Revolution

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middin, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Feb Flossie M. Davis 8:50 A М 4. SOCIAL SECURITY NUMBER B. AGE (In vrs. last birthday) 8. BIRTHPLACE (State or Foreign IF INDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) Feb. 1, 1917 220-01-7865 78 HOURS 1 M 2 X F Maryland 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Deer's Head Center Salisbury Wicomico RESIDENCE OF DECEDENT 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Cambridge 1 XYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 503 Muir Street, Apt. 206 21613 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rid 1 YES 2X NO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 3 X Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 7th Housekeeper Domestic 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at James Everett Conaway BE Augusta Jones 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 4664 Cloverdale Road, Clayton Roberts Rhodesdale, MD 21629 2 20e. METHOD OF DISPOSITION
1 № Burlel 2 □ Cremalion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Salem Cemetery

Salem Cemetery ☐ Donetion 5 ☐ Other (Specify) Salem, Maryland 21. SIGNATURE OF FUNERAL BERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home 601 Race Street, Cambridge, MD 21613 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition Renal failure and Congestive Heart failure vear reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus CERTIFICATION Sequantisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING Hypertension **CAUSE** (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? Cerebrovascular accident - R. Hemiglelia 1 TYES 2 NO Pulmouary Tuberculosis 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 No Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1X Netural 5 Pending Investigation BY 1 YES 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TO THE HOSPITAL OF THE FUNERAL DE FILES WITHIN 72 ho

2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated.

29c. LICENSE NUMBER

D16278

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

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		it. Pages 1, 2, 3 should
1215-0020	or attending physician.	etely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	5 should be detached for
ALTIMORE, I	death. Page 6 may be	funeral director, page
B,	this nours after	etely filled in by the

DIVISION OF VITAL RECORDS. P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Gours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entroal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARY									
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEAT	N		3. TIME OF DEATH	
	Gerald Charles	Duggan					REG NO. 2. DATE OF DEATH MONTH PEDTUARY 26, 1995 1:40	1 • / O D	М		
TABLE OF THE PRINCE OF THE PRI	PLACE (State or Foreign										
		1 1	77_ Y	RS.			March 10		,	,	
	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY	, TOWN OR LO	CATION OF D	EATH		9c. COUNTY OF DEATN		
5	Holy Cross Hospi	ltal		Si	lver S	oring		Мо	Montgomery		
E C			10	c. CITY, TOWN	OR LOCATION						
	Maryland Mon	ntgomerv		Silver Spring					1 YES 2 NO		
AL						10g. CiT	10g. CITIZEN OF WHAT COUNTRY?				
ij						20901			U.S.A	١.	
5					WAS DECENDE	NT OF HISPA	NIC ORIGIN? (Specifien, Puerto Ricen, etc.	y Yaa or No—	a or No — 14. RACE — American Indian,		
	3 Widowed 4 Divorced										- 1
8	15, DECEDENT'S EDI	UCATION					16b, KIND OF	BUSINESS/INC		ite	\dashv
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ш		Duggan							2.0		
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	1 XBurial 2 Cremation 3 Ran	noval trom Stata	cemetery cremetor	v or other place!							J
		CENSEE	Gate of	Heave	NAME AND AD	DRESS OF FA	S/2/95 S1 NCILITY	lver Spring, Maryland			\dashv
	Man ex C	andre .	CERTIFICATE OF DEATH S. Date of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death of Control of Death Death of Deat								
	23. PART i. Enter the diseases, or	complications that cause	ted the death	Do not enter	00 Univ	versit	y Blvd.,	W. Sil	.Spr.		4
	shock, or heart failure.	List only one cause or	eech line.	A THOU CINE	the mode of	dying, suc	A cardiec or n	espiratory an	rest,	interval Between	
	disease or condition - Osophassal varices Consular									Sold and Death	n
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	PART II. Other significant condition	ns contributing to death	but not resul	ting in the ur	derlying cau	se given in	Part I. 24a. WAS				
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Ä		26a. DATE DF INJUR	Y 286	. TIME OF	28c. INJURY A			OW INJURY OC	CURED		\dashv
		(Month, Day, Year	r)	INJURY M		2 NO					١
	3 Suicide 8 Could not be	26a. PLACE OF INJU	RY — At home, fr	erm, street, tact	ory, offica				or Rural Ro	oute Number,	┪
	4 Nomicide determined						City or lown, S	tate)			1
2	29a. CERTIFIER (Check only	ICIAN: To the best of my kn	owledge, death o	courred at the t	me, data and p	aca, and dua	to the cause(s) and	manner as stat	ted,		
OM										and manner as stated.	1
	SIGNATURE AND TITLE OF CERTIFIE	B. //- ,	. 0	7,	290	LICENSE NUI	MBER				1
	Heave M.	Long	HAC	LM	Q) 1	121	21	▶2	-2	6-95	1
F	30, NAME AND ADDRESS OF PERSON W	O COMPLETED CAUSE OF	DEATN (ITEM 27)	(Type, Print)	1					-	7
	George F. Sengsta	ck, M.D. 3	929 Fer	rara D	rive V	Theato	n, Maryl	and 209	906		
	TED 28 1995	FILL O MUSICO	GNACHE CALL								
	LED - 1999	0			<u> </u>						
										DHMH-18 Rev 1/	189

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the normal part of the retained by the law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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A	mended #1	STATE OF MARYLAN	D / DEPAR	RT TMENT OF	Mon7	Gome MENTAL HYGIEN	95 F 7	Co	unty		
	REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO			- O		
	1. DECEDENT'S NAME (First, Middle, Last)	1	7	11		2. DATE OF DEATH	AY	YEAR	TIME OF DEATH		
	Robert L. Dudley			1916X		February	22, 19	995	8:45 A M		
		-	rs. last birthday)	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Country)	ACE (State or Foreign		
	301-03-4037		YRS.			Sept. 16,					
DIRECTOR		9e. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Brooke Grove Nursing Home Olney Montgome									
<u>일</u>	10e. STATE 10b. COUNTY		10c, CITY	, TOWN OR LOC	ATION			10-	d. INSIDE CITY		
뜸	Maryland Montgo	merv	Ga	ithers	ourg				LIMITS?		
1 1	10e. STREET AND NUMBER	inoz j			of, ZIP CODE		10g. CITIZI		T COUNTRY?		
FUNERAL	9888 Brookridge C	ourt			20879						
3		2. WAS DECEDENT EVER IN U.		13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify Ye	-	ed St	American Indian,		
BY	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATE: WWII, Korea		If yes, s	pecify Cuban, Maxico S 2 X NO Specif	an, Puarto Rican, atc.)		Black, W Specify:	onto, atc. White		
8	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION 16		USUAL OCCUPAT		16b. KIND OF BU	SINESS/INDU				
COMPLETED		College (1-4 or 5+)	Supervi	e retired.)	iosi or working	Div. Pa		Dech	n to d' n m		
8	17. FATHER'S NAME (First, Middle, Last)	31	Supervi	.501	18 MOTHER'S NA	ME (First, Middle, Malden		PLOD	ation		
Ü	Fred E. Dudley					B. Hollen					
00	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or Tox		Code)			
입	James Edward Dudle	v	1			t, Gaither			20879		
	20a. METHOD OF DISPOSITION	20h PI	ACEANDDATEG	E DISPOSITION //	Vama of	DATE 20c 10	CATION C	the or Town	Stele		
	1 Buriel 2 □ Cremation 3 □ Remova □ Donation 5 □ Other (Specify)	from Stata cemeter	y, crematory or oth	herplece) Nationa	al Cem. 2	/28/95 Ar1	ingto	n. Vi	roinia		
	GNATURE OF FUNERAL SERVICE LICEN	SEE	, O	22. NAME /	AND ADDRESS OF FA	VCILITY DeVol	Fune	ral H	ome		
Ц	Mechant	D(gel	lun	10 Ea Gaith	ast Deer nersburg,	Park Drive MD 20877					
	23. PART i. Enter the diseases, or con ahock, or heart failure. Lis iMMEDIATE CAUSE (Final	nplications that caused the tonly one cause on each	a death. Do n	ot anter the m	oda of dying, aud	th as cardiac or reap	iratory arra	at,	Approximate interval Between Onset and Death		
	disease or condition resulting in death)	Pneumonia							3 weeks		
	resulting in death) a	DUE TO (OR AS A CO	NSEQUENCE OF):							
ATION	Sequentially list conditions, b	DUE TO (OR AS A CO	NSEQUENCE OF):			_				
SAT	if any, leading to immediata cause. Enter UNDERLYING										
CERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):							
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	PART ii. Other algnificant conditions of	contributing to death but	not reaulting in	n tha underlyi	ng cause given in			24b. WE	RE AUTOPSY FINDINGS		
MEDICAL	Advanced Alzhei	mer's Dement:	ia			PERFO		co	VILABLE PRIOR TO MPLETION DF CAUSE		
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=	DID TOBACCO USE CO	ONTRIBUTE TO C	AUSE OF	DEATH	YES NO	N C] 123 2] 110		
A	25. WAS CASE REFERRED TO MEDICAL			26. 1	PLACE OF DEATH (C/	neck only one)					
SIC		IOSPITAL:	nt 3 🗆 DOA	OTHER:	me 5 🗆 Realdence	8 Other (Specify)	W				
27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED											
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		YES 2 NO						
	3 Suicide 8 Could not be	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, at	treet, factory, off	lca	28f. LOCATION (Street	and Number o	r Rural Route	Number,		
тер	4 Homicide determined	and (openy)				City or Town, State,	,				
COMPLET	29a. CERTIFIER Check only	N: To the best of my knowledg	e, death occurre	d at the time, da	ta and place, and due	to the cause(s) and ma	nner as states	d.			
NO.		On the basis of exemination an							d menner as stated,		
	295 GHOMATURE AND TITLE OF CERTIFIER				29c. LICENSE NU				onth, Day, Year)		
BE	/ / - /	STAFF PHYSY	CLAN		D42	1 .			L-95		
2	30 WANT AND ADDRESS OF BERSON WHO C		######################################	270	1 - 12	~ 14			~-13		

DYZO46 STAFF PHYSKIAN 30. DAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

G. BLOOKE GOBGE 18100 Stade School

31. DATE FILED (Month, Day, Year)

MAR 02 1995 Julia Murulan Randall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

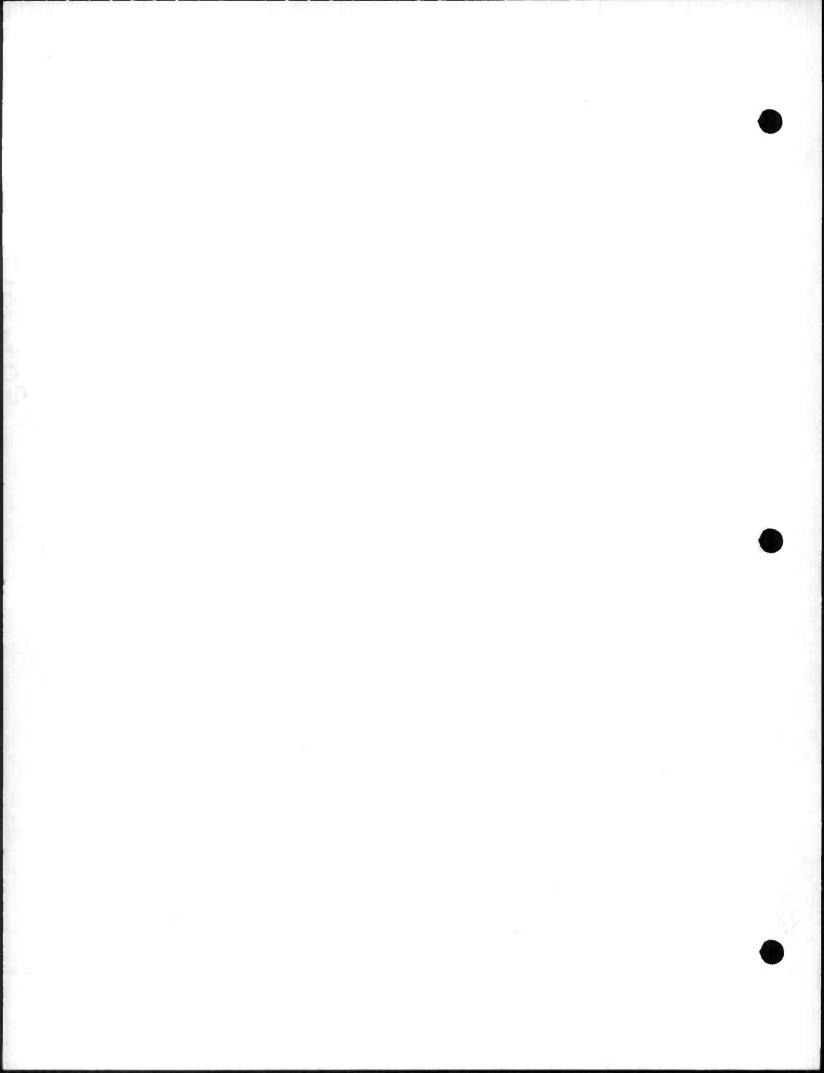
Frank Lin, M.D.

31. DATE FILEO (Month, Day, Year)

FFB 27 1995

A	nended # 16 E 1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT CERTIFICATION	NT OF HEALTH AND	MENTAL HYGIEN	95 d	977.84				
	1. DECEDENT'S NAME (First, Middle, Last)	Linda Louise	Davis		2. DATE OF DEATH MONTH D		3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 220-42-3732	5. SEX 6. AGE (In yrs.		DER 1 YEAR IF UNDER 24 HRS.	February 2		1:35 P M HPLACE (State or Foreign				
	220-42-3732	1 □ M 2 💢 F 52	YRS. MONTH	B DAYS HOURS MIN.	Dec. 7,194	Coun	ryland				
_	9e. FACILITY NAME (If not institution, give street	et and number)	9b. CI	TY, TOWN OR LOCATION OF E		9c. COUNTY OF					
DIRECTOR	4720 Tallahassee A	Montgom	ery								
12	10a. STATE 10b. COUNTY		10c. CITY, TOWI	OR LOCATION			10d. INSIDE CITY				
	Maryland Montgo	omery	Rocl	kville			1 TES 2 NO				
FUNERAL	10e. STREET AND NUMBER	A		10f. ZIP CODE			WHAT COUNTRY?				
18	4720 Tallahassee A	AVENUE 12. WAS DECEDENT EVER IN U.S.	ARMED 1	20853 3. WAS DECENDENT OF HISPA	INIC ORIGIN? (Specify Ven		SA E — American Indian.				
B	1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES		If yes, specify Cuban, Mexic 1 ☐ YES 2 💥 NO Spec	en, Puerto Rican, etc.)	Blac	ck, White, etc. White				
TED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	empleted)	DECEDENT'S USUAL	ne during most of working	18b. KIND OF BUS	SINESS/INDUSTRY					
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	iile. Do NOT use retired	,	Fr	intine	-1				
NO N	17. FATHER'S NAME (First, Middle, Last)	D	ookkeepei		AME (First, Middle, Maiden	nging Sumame	-				
TO BE COM	Frederick K. Joh	nson			Everhart	ourname)					
10 10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AODRE	SS (Street and Number or Rura	Route Number, City or Town						
	Clifford E. Davis		4720 Tal	<u>lahassee Ave</u>	. Rockville	ckville, MD 20853					
	20e. METHOD OF DISPOSITION 1	ni from State comotory	ce and date of dispersions of their place Lawn Memo		OATE 20c. LO						
gyguilla	21. SIGNATURE OF FUNERAL SERVICE LICEN	///lella	² H	rancis J. Co 00 Universit	llins Funer	ral Home	, INc.				
ל מפוור, וופ וופפונקו	23. PART I. Enter the diseases, or conshock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	23. PART I. Enter the diseasea, or ofinplications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition									
ERTIFICATION	Sequentially list conditione, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONS									
PHYSICIAN: MEDICAL CE	PART II. Other algolificant conditions of	contributing to death but no	t reculting in the	undariying ceuse given ir	Part I. 24e. WAS AN PERFOR	MED3/	D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE				
ME				1.			DF DEATH?				
N.	DID TOBACCO USE CONTRIB				N 🗆						
SICI		HOSPITAL:	ACE OF DEATH (Chec	ER:							
H	1 YES 2 NO 1	□ Inpatient 2 □ ER/Outpatient 26e. DATE OF INJURY	3 DOA 4 N	ursing Home 5 PResidence	1	IIIBA OCCIBED					
3 Suicide 6 Could not be building, etc. (Specify) 289. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Numb City or Town, State)							Route Number,				
COMPLET		AN: To the best of my knowledge,					s) and manner as stated.				
	296. SIGNATURE AND TITLE OF CERTIFIER	1/		29c. LICENSE NU		29d. DATE SIGNED					
O BE	Trank 1	Tu us_		1 43	3199	1 2/2	+195				
I F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (I	TEM 273 (Sono Drint)	12.00	-	-					

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 43199 10301 Georgia Avenue #205 Silver Spring, MD 20902



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	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR	TMENT	OF H	IEALTH AN	D MENTA	AL HYGIEI REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DAT	E OF DEATH	DAY	YEAR	3. TIME OF DE	ATH
	Jane D. Davis								ruary			3:10	Рм
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR DAYS	IF UNDER 24 HF	40.0	E OF BIRTH		a, BIRTH Countr	IPLACE (State or	Foreign
	212-30-7596	1 M 2 X F	68_	YRS.	months .	DATS	HOURS		. 20, 1	926		" Jersey	
	9a. FACILITY NAME (If not institution, give s				9b. CITY,	TOWN C	OR LOCATION O	F DEATH		9c. CO	UNTY OF D	EATH	
DIRECTOR	Suburban Hospita	1			F	Beth	esda			N	lonta	omery	
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v		100 017	Y, TOWN O	010047	no.						
E												10d. INSIDE CE LIMITS?	
	Maryland Mon 10e. STREET AND NUMBER	tgomery			Rocky		. ZIP CODE					1 X YES 2	
FUNERAL	5 Pace Place					101						VHAT COUNTRY	
	11. MARITAL STATUS	12. WAS DECEDENT 8	VED IN U.S. AD	MED	100	2000	20852					States	
	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR	YES 2 X	10	11	yes, spe	ENDENT OF HIS ecity Cuban, Ma 2 X NO Sc	xican, Puarto	Rican, etc.)	ea or No-	14. RACE Black Speci		
ED	15. DECEDENT'S EDU		16a. DE	CEDENT'S	USUAL OC	CUPATIO	ON .	16	b. KIND OF BI	JSINESS/IN	DUSTRY	White	3
COMPLET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	ve kind of a Do NOT us	work done o se retired.)	luring mo	st of working	-					
립		5+		Tea	cher				Scho	201			
Ö	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S	NAME (First,					
ш	Stanton Davis						Rutl	n Noe					
10 B	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS	(Street a	nd Number or Ru		nber, City or To	wn, State, Z	(ip Code)		
ř	C. Stanley Davis		5	Pac	e Pla	ce,	Rockv:	ille.	Marvla	and	20852	2	
	20a. METHOD OF DISPOSITION 1	and down Cons	20b. PLACE	ND DATE	OF DISPOSI				_		- City or To		
	4 Donation 5 Other (Specify)	IOVIII FROM STATE	Monta	omery	v Cre	mate	orium.	28,1 Inc.	I Ret	hesd	a. Ma	aryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	M	0083	1 22.1	AME AN	D ADDRESS OF	FACILITY	T. Fire	2000	II-ma	/ mery 50-2805	
	*Thebara Cht	mmwlb.	Nous	reno	RC RC	ckv	ille,	Inc. 3	00 Wes	st Mo	ntgor	nery	
-	23. PART i. Enter the diseases, or	emplications that c	eused the de	eth Do r	At anter	enu	e, Roci	cville	, Mar	yland	2085		
- 1	SHOCK, OF heart failure.	List only one cause	on each line		ot antor	1110	de or dying,	aucii aa cai	diec or rest	matory a	rreat,		Between
	iMMEDIATE CAUSE (Final disease or condition			4		-	- 4	1	10			Onset ar	nd Death
ŀ	resulting in death)	a. CARC DUE TO (OI	R AS A CONSEC	HENCE O	67	- (the	cu,	9			5 ~	10.
- 1		552 10 (6)	AS A CONSEC	OENCE O	r):								
ERTIFICATION	Sequentially list conditiona,	b DUE TO (OF	R AS A CONSEC	UENCE O	PI-							-	
4	if any, leading to immediate cause. Enter UNDERLYING				,-							İ	
吕	CAUSE (Disease or Injury that initiated events	DUE TO (OF	R AS A CONSEC	UENCE O	F):							-	
=	resulting in death) LAST											j	
3		d										-+-	
MEDICAL	PART II. Other significent condition	s contributing to de	ath but not re	esuiting	in the un	deriying	cause given	in Part i.	24a. WAS AI PERFO		24b.	WERE AUTOPSY AMAILABLE PRIOR	
3									1 TES			COMPLETION OF OF DEATH?	
Ä												1 YES 2 X	NO
SICIAN:	DID TOBACCO USE CONTI	RIBUTE TO CAUS	SE OF DEAT	TH YE	SON	10 🗆	UNCERT	AIN 🗆					
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLAC	E OF DEAT	TH (Check o	nly one)							
2	1 TES 2 DO	HOSPITAL:	R/Outpetlant 3	□ DOA	OTHER		5 🗌 Residen	ca 8 🗆 Othe	er (Specify)				
	27. MANNER OF DEATH	28a. DATE OF IN. (Month, Day,	JURY Year	28b, TIM		28c. INJU	URY AT	28d. DE	SCRIBE HOW	INJURY O	CCURED		
	1 Netural 5 Pending 2 Accident Investigation	(moran, bay,	,	INIJ	URY M	1 N	ES 2 NO						
	3 Suicide 8 Could not be	26e. PLACE OF III building, etc.	NJURY - At hor	ne, larm, s	street, facto	ry, office	,	281. LOC	CATION (Street	and Numbe	or or Rural R	oute Number,	
	4 Homicide datarmined	January, etc.	. (City	or Town, State	7			
	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSI	CIAN: To the best of my	knowledge des	th occurr	ed at the He	De detc	and place and	due to the co	usata) and		ete d		
Σ∥		R: On the basis of axam										and manner or	atated
3	299/55/GMATURE AND TITLE OF CONTROL				, . ,	7			and piece, i				
H	- 11						29c. LICENSE	-		29d. DA	TE SIGNED	(Month, Day, Year)
o	mand Wohen						009	11	7			26-9	5

RSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

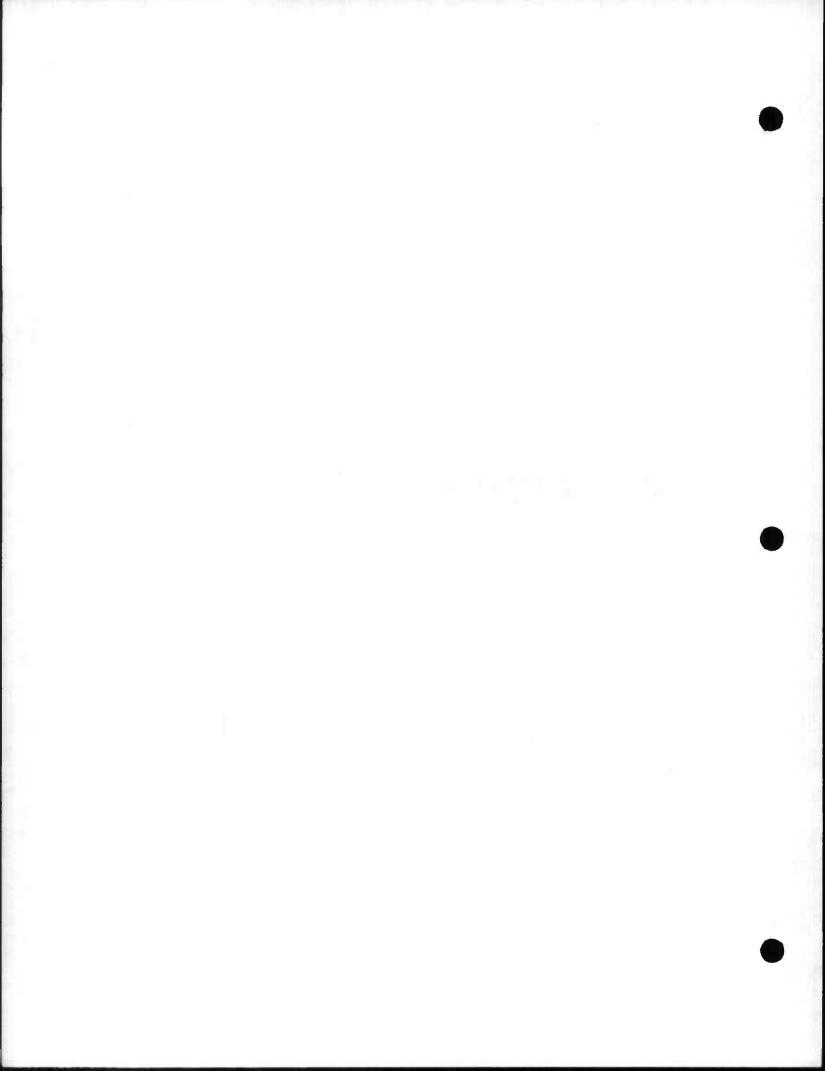
32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Vear)

FFR 28 1995

DHMH-18 Rev 1/89

20895 10400 Connecticut Avenue, Kensington, MD

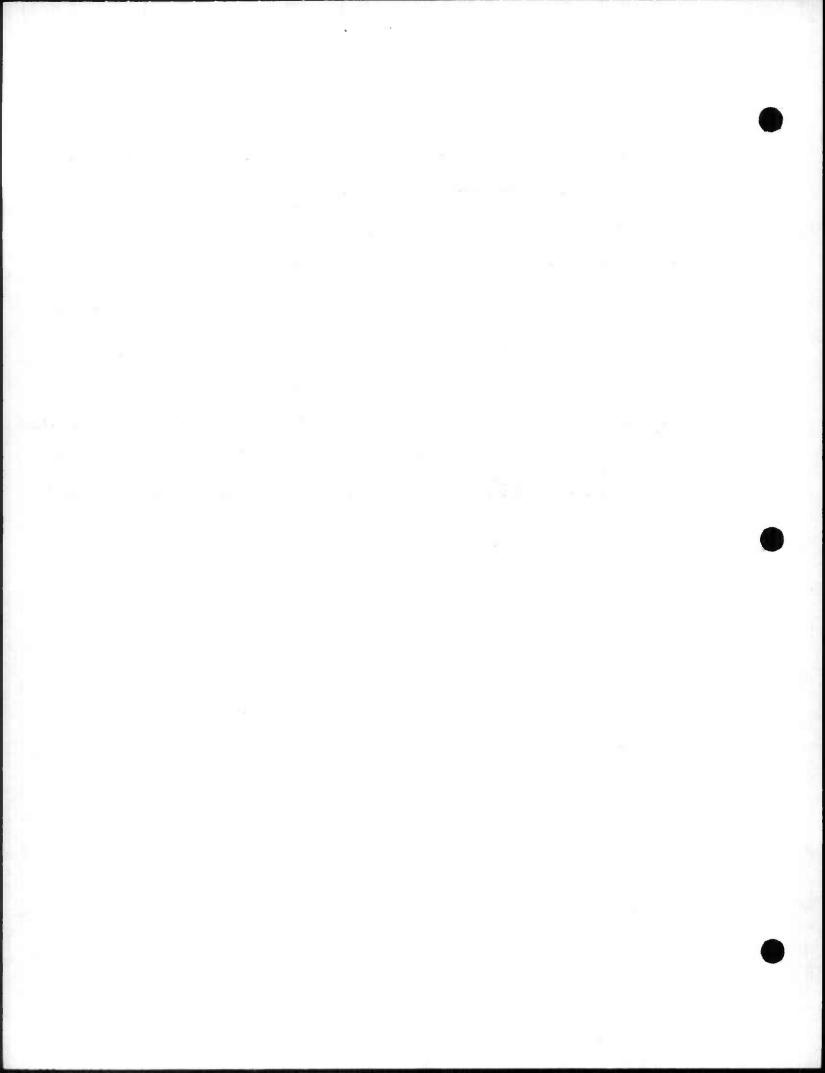


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Middle, Last	1)				2. DATE OF DEATH	- 70	3. TIME OF DEATH
		VIOL	_A DE	AN			MARCH 2		
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BI	RTHPLACE (State or Foreign
10		370-26-6715	1 M 2 F	79 YRS.	MONTHS DAYS	HOURS MIN.	April 7.7	915 5	untry) Carolina
should		90. FACILITY NAME (If not institution, give	street and number)		96. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY O	F DEATH
2,	l o	Prince George	s Hospita	1	Che	10-14		Prince	e Genera
		RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY	40c CIV	Y, TOWN OR LOCAT			7/1///	0
Page	DIRECTOR	Maria I D	C	00.4	, I I	11. 11			10d. INSIDE CITY LIMITS?
amit it		100. STREET AND NUMBER	e beirge	L(A)	aital 100	THEIS N+S		10- CITIZEN C	1 TES 2 NO
physician. burial-transit permit. Pages 1,	FUNERAL	P.O Box 31:	286		1.00	20731		log. CITIZEN C	A A
physician burial-trar	3	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC		NC ORIGIN? (Specify Yee	or No.— 14. R	ACE — American Indien,
		1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, sp	ecify Cuben, Mexico	n, Puerto Rican, etc.)		leck, Whita, etc.
attending se as the	В В							"	Black
3	COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	(Give kind of	USUAL OCCUPATION	ON ist of working	16b. KIND OF BUS	INESS/INDUSTR	Y
opital of	12	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT u	P		-1	0	1. 1
the hospital detached fo	MC	17. FATHER'S NAME (First, Middle, Last)	27	Jupe	rvisor	40 1407147710 144	rec	700	+
by the be dett	ECC	Oscar I	Dudgu - Ha	•		IA 11/	ME (First, Middle, Meiden	Surname)	
retained by the hospital of should be detached for notified at once.		19e. INFORMANT'S NAME (Type/Print)	JUENWY IN	19b. MAILING	ADDRESS (Street a	nd Number or Prival	Poute Number, City or Tolk	, State, Zip Code	
e reta e 5 sh noti	5	Fay Jackson		7510	1. /11	411	- 1 1		MD STARE
may be		20e. METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITION (No	me of	DATE 20c. LOC	CATION - City of	Town, State
e 6 ma ector, g		1 @ Buriel 2 Cremation 3 Red 4 Donation 5 Other (Specify)		metery, crematory or o		neton 3	Valer B	card	IMD
Pag ral di liner		21. SIGNATURE OF FUNERAL SERVICE L	JCENSEE		22. NAME AN	O ADDRESS OF FA	dury	And do.	
the death. Page 6 may be the funeral director, page one.		1 Ilan	90		11.	1	1 11	1	1440
after thy the mosal	\vdash	23. PART I. Enter the deeses, or	complications that cause	ed the deeth. Do r	of enter the mo	de of duing and	Home,	HGLAS	ed lall
filed in by th on, or remova the medical		snock, or heart failure	List only one cause on	eech line.		ao or aymg, aco	, on cordine of respir	atory private,	Approximate Interval Between
D 10 10 10 10 10 10 10 10 10 10 10 10 10		IMMEDIATE CAUSE (Final disease or condition	Condini	ALL	+				Onset and Desth
		resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF	F):				
nd con burial, affic en	z	2	· Aeu	te Mi	<i>T</i>				
8 7 5 6	일	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	F):				
cate others of price of price of the price o	2	CAUSE (Disease or injury	C						
th certificate ending physical Hygiene pro-	Ë	thet initiated evente resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	F):				
5 5 0	CERTIFICATION		d						
that the deal ned by the att th and Menta any Injury,		PART ii. Other significent condition	ons contributing to death i	but not reculting	n the underlying	ceuse given in	Part i. 24a. WAS AN /		4b. WERE AUTOPSY FINDINGS
signed by 1 Health and WE any In	MEDICAL						1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
requires been signe of Health	ME								1 YES 2 NO
law requisite been ept. of 1	ž	DID TOBACCO USE CONT	TRIBUTE TO CAUSE C	OF DEATH YE	S 🗆 NO 🗆	UNCERTAIN	NØ		
The ate ha	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEAT					
CIAN: ertifica he Si	YS	1 TES 2 KNO	1 Oinpetient 2 - ER/Out	patient 3 🗆 DOA	OTHER: 4 Nursing Home	5 Residence	8 Other (Specify)		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23:	РНУ	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIM	URY WO	RK?	28d. DESCRIBE HOW IN	JURY OCCURED	
After Jeath	BY	2 Accident Investigation	28 PLACE OF IN HIS	Y AA barra (ES 2 NO			
TEND TOR: Jaffer of	ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	r — At nome, tarm, a ncify)	Rreet, tectory, office	·	281. LOCATION (Street er City or Town, State)	nd Number or Run	al Route Number,
OR AT	LETEI	29e. CERTIFIER							
TAL C	COMPL	(Check only one) 2 MEDICAL EXAMIN	SICIAN: To the best of my know	viedge, death occurre	d at the time, date	end place, end due	to the ceuse(e) end mani	ner ee atated.	
FUNE within	8		ER: On the basis of examination	on entror investigatio	n, in my opinion, de			due to the ceue	e(e) end menner ee stated.
THE fled POR	BE	29b. SIGNATURE AND TITLE OF CERTIFIE	R / Rahmi	∞ 1)		29c. LICENSE NUM		29d. DATE SIGN	ED (Month, Day, Yeer)
₽ ₽ 2 조	၉	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Time-	Print)	D 307	0 1	3	3 PJ
					rim)				
		RAKECHI	CAHNII		- R.11.	Orient.	10 13-	1 (.)	1 mn 1.7
		RAKESH (31. DATE FILED (Month, Day, Year)	2 SAHNI J2. REGISTRAR'S SIGN Salin DRUCKER	7715	Belle	Point	DR. Gre	enbel	1, MD20770



TO THE HOSPITAL DR ATTENDING PHYSIOLAN: The law requires that the death certificate be executed within Exhours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

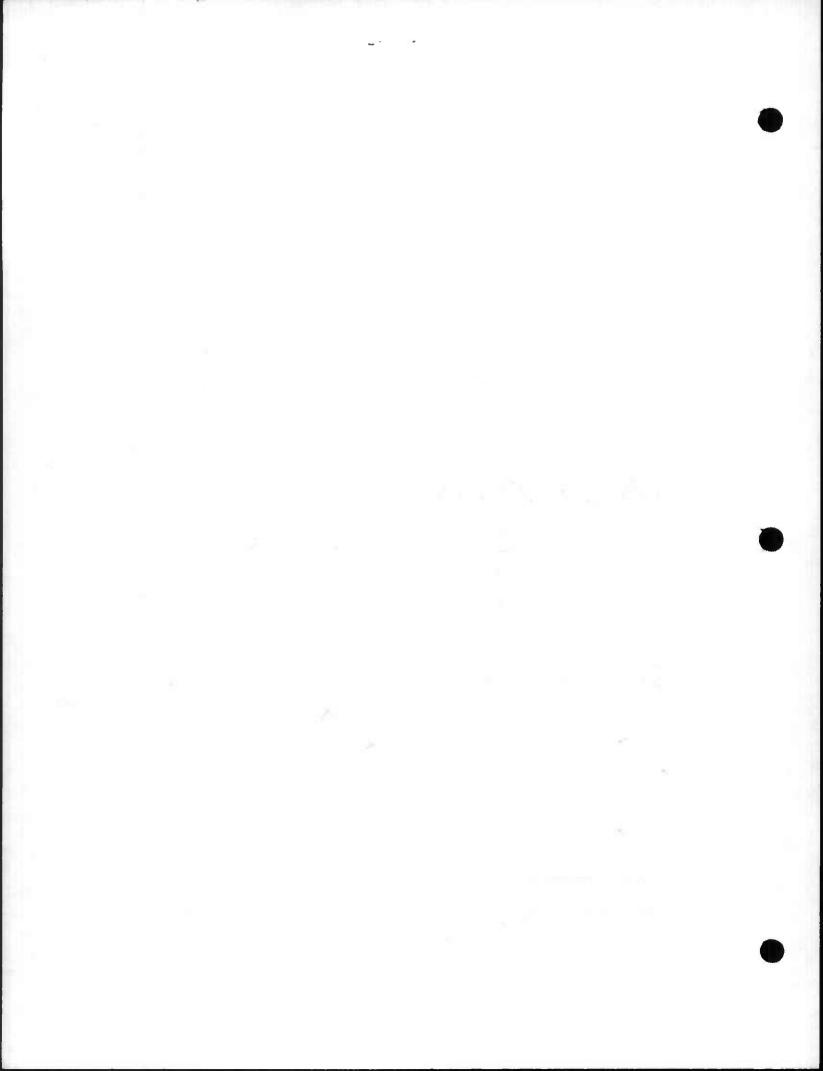
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN				CERTIF	ICATE	UF	DEA	<u> п</u>		REG. NO			
9	1. DECEDENT'S NAME (First		Edna Gra	ace En	twisle					2. DATE MONTE	of DEATN 0	9̃5	YEAR	3. TIME OF DEATH A
0.00	4. SOCIAL SECURITY NUMBER 577-84-398		5. SEX	6. AGE (In yrs	s. last birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS.	7. DATE (Mont	of BIRTH		Count	
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9h CITY	MWW OI	R I OCATI	ON OF O		0, 15			yland
Œ	Manor Care					9b. CITY, TOWN OR LOCATION OF OEATN						9c. COUNTY OF DEATN		
18	RESIDENCE OF DEC		ing mane			قىل.	urgo					Pı	cince	George's
Ĭ	10a. STATE	10b. COUNT	Y		10c. CIT	Y, TOWN OR	LOCATI	ION						10d. INSIDE CITY
L DIRECTOR	Maryland 100. STREET AND NUMBER	e's	For	estv								LIMITS? 1 YES 2 NO		
FUNERAL	3801 Fores	tville	e Road				101.	ZIP CODE						States
5	11. MARITAL STATUS		12. WAS OECEDEN	T EVER IN U.S	ARMEO	13. W	AS DECE	ENDENT O	F NISPAI	NC ORIGI	N? (Specify Yes			E — American Indian, k, White, etc.
BY F	1 Never Married 2		FORCES? 1	YES 2	XINO	1 (YES	2 XNO	n, Maxica Specif	n, Puerto y:	Rican, etc.)		Spec	
E	15. DEC (Specify only	EDENT'S EOU	CATION completed)	16a	OECEDENT'S	USUAL OCC	CUPATION	N it of workin	na .	168	. KIND OF BUS	SINESS/IN	OUSTRY	WIIICE
COMPLETED	Elementary/Secondary (0	-12)	College (1-4 or 5	+)	Ille. Do NOT us	e retired.) ISEWif					Home			
N	17. FATNER'S NAME (First, M	iddle, Last)			1100	ISCMTI	.e	16 14071	IEDIC NA	ME (5)-1	Home Middle, Maiden	^ -		
BE C	UNKNO	2317	Arm	strong							Measel]			
	19a, INFORMANT'S NAME (7				19b. MAILING	ADDRESS (Street an				ber, City or Town		o Codel	
임	Eugene Entw	isle									estvi]			0747
	204. METHOD OF DISPOSITI	ON Born	complete Charles	20b. PLA	CE AND DATE	F OISPOSIT	ION (Nam	ne of	lala 1	DAE N	FO 1 20c. LO	CATION -	City or To	wn, Stata
	4 Donation 5 Other	(Specify)		Epi	phany	Episo	soog	1 Ce	m	1	FOR	restr	7i 1 1 e	bre IvreM
	21. SIGNATURE OF FUNERA	SERVICE LIC	CENSEE	0		22. N/	AME AND	D AOORES	S OF FA	CILITY I	ee Fur	neral	Hom	e, Inc 6633
	Stanlo	11.5	Mar	1 de	1	010	Al	exan	der	Ferr	y Road	d, Cl	into	n,Md 20735
	23. PART I. Enter the di	leases, or o	complications the List only one cau	t coused the	deeth. Do r	ot enter ti	na mod	le of dyl	ng, suc	h aa care	diac or respi	retory ar	reat,	Approximate
	IMMEDIATE CAUSE (Fin													Interval Batween Onset and Daath
	disease or condition resulting in death)	+	· Ca	(OR AS A COM	pulm	onan	5	as.	res	t				
						7):								
CERTIFICATION	Sequentially list conditi	ona,	b. DUE TO	OR AS A COM	SECUENCE OF	D.								
Ä	If any, leading to immed cause. Enter UNDERLYI	NG	PN	PUROLL			- 106	550	1/0-	, 6	iccid	12 0	1	
E	CAUSE (Disease or Inju that initiated events	ny 1	DUE TO	(OR AS A CON			00-0	0 2 0	7		100700			
	resulting in death) LAS	r H	4											
	PART II Other significa	at acadition		4 11 1										
EDICAL	PART II. Other aignifica		s orde		ot resulting i	n the unde	erlying	cause g	iven in	Part I.	24a. WAS AN . PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	Seizon	E DI	7 orce							- 1	1 YES 2	KNO		COMPLETION OF CAUSE OF OEATH?
2	DID TORACCO III	CE COLE	NO. ITTE TO CA											1 YES 2 NO
A	DID TOBACCO U		KIBUIE 10 CA				. 4	UNC	ERTAIN	1 0				
PHYSICIAN:	EXAMINER?	MEDICAL	HOSPITAL:		LACE OF DEAT	QTHER:								
1YS	1 YES 2 NO		1 Inpatient 2 I			4 Nursin		_	aldence					
	_	Pending	(Month, D		26b. TIM	URY	WOR		1 110	26d. DES	CRIBE NOW IN	NJURY OC	CURED	
ВУ	a D a titl	nvestigation	28e. PLACE O	F INJURY — A	t home form a			2 2	NO	201 1 00	ATION CO.	-4.85 - 5		
TED		Could not be letermined	building,	etc. (Specify)	i rome, miti, a	areat, tactor;	y, office			City	ATION (Street e or Town, State)	nd Numbel	r or Humil H	oute Number,
3	290. CERTIFIER	IFYING PHYSI	CIAN: To the beat of	mu knowledge	death comm	d at the star	44	4 11 1	0.15		7.51=5.5			
COMPLET														and menner as stated.
	29b. SIGNATURE AND TITLE					, -,-					pve, all			
B	C+-	/	-mp					29c. LICE	D 3	797	4	Zyd. DAT	SIGNEO	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM 27) (Type	Print)			4)	/ / ->	/		-142	175
	Stephan	« Tr	follo	MD	7500		enw	4	Ch	D.L	e Gre	en bo	BA	06605 Q
	31. DATE FILEO (Month, Day, 1)	8 1995	32. REGISTRA	RIS SIGNATUR	Rardall									



BALTIMORE, MARYLAND 21215-0020

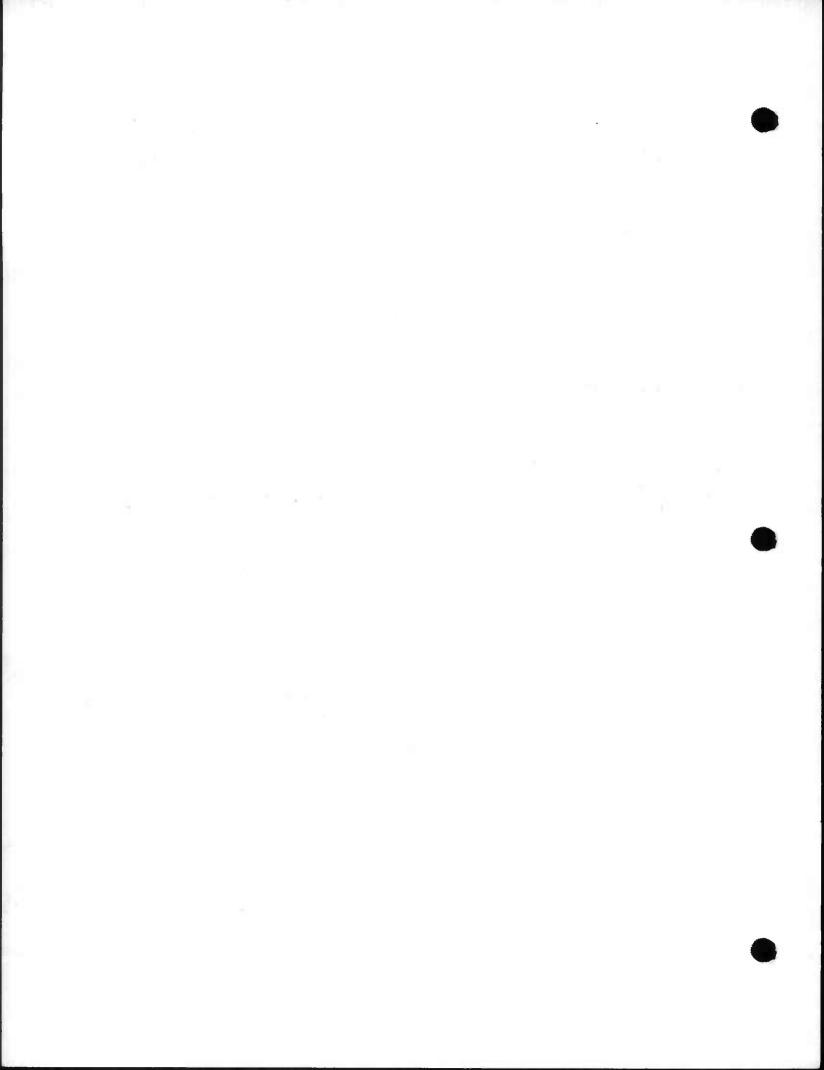
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. nours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTI	FICATE O	F DEATH	R	EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	0	1	11.5	2. DATE OF I	DEATH	YEAR	3. TIME OF DEATH
	Irma	6. AGE (In yrs. last birthday	1	1113	2	21	95	2240 "
	4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M	Country	PLACE (State or Foreign) aryland					
NC.	9. FACILITY NAME (If not institution, give street and not present the PENINSULA REGIONAL ME		September 14,190\$ Maryland vn or Location of Death .ISBURY September 14,190\$ Maryland .ccounty of Death WICOMICO					
5	RESIDENCE OF DECEDENT							
DIRECTOR	Maryland Wicomi		TTY, TOWN OR LOC	CATION				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	20	Hebron	10f, ZIP CODE		I 40 - 41		1 X YES 2 NO
FUNERAL	304 North Main St.			21830			US	A COUNTRY?
B	1 Never Merried 2 Merried FORG	DECEDENT EVER IN U.S. ARMED CES? 1 YES 2 NO S, GIVE WAR OR DATES	13. WAS D If yee, 1 - Y		RACE — American Indian, Black, White, etc. Specify:			
띹	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DECEDENT	'S USUAL OCCUPA	TION	16b. K/N	D OF BUSINESS/IN		
COMPLETED		(1-4 or 5 +) Homema	of work done during in use retired.) aker	nost of working				
Š	17. FATHER'S NAME (First, Middle, Last)			18, MOTHER'S NA	ME (First, Middle	, Maiden Surname)		
BE (0wens				Bailey		
2	19a, INFORMANT'S NAME (Type/Print)			t end Number or Rural i			Zip Code)	
	Elva Dorman			, Quantic				
	20e. METHOD OF DISPOSITION M Buriel 2 Cremetion 3 Removal trees 4 Donalion 5 Other (Specify)	State 20b. PLACE AND DATE cemetery, cremetory or Hebron (other plece)		0ATE 2/25	Hebron		n, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1/	22. NAME	AND ADDRESS OF FA	CILITY		i, mb	
	WK Jal	un	501	Snow Hil	1 Rd	Salisbu	ry, M	D 21801
	23. PART I. Enter the disease, or complicat shock, or heert failure. List only IMMEDIATE CAUSE (Finel disease or condition	one ceuse on Vech line.		4				Approximete interval Between Onset and Death
	resulting in deeth) e	ONTERNAS CLE	OF):	- ayear	7 300	· ·	C	yars
N	Sequentially list conditions,			leriosc	lecor	u		Gears
ATI	If any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE	OF):					/
FIG	CAUSE (Disease or Injury	DUE TO (OR AS A CONSEQUENCE	on:					
CERTIFICATION	thet initiated events resulting in death) LAST	The state of the s						
	PART II. Other significant conditions contrib	uting to death but not resulting	a In the underlyi	na sauce alven In	Book Lau	WAS 111 ALERSON		
EDICAL	Transient Ische	mic allace	l.	ng cedae given in	Part I. 24a.	WAS AN AUTOPSY PERFORMED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE
EDI	(D) -+ 0 11		earlit.	Deales	, ,	YES 2 X NO	1	DF DEATH?
Σ.	DID TOBACCO USE CONTRIBUTE	TO CALLSE OF DEATH V		Defres				1 TYES 2 NO
A N	25. WAS CASE REFERRED TO MEDICAL		ATH (Check only on		101			
Sic	EXAMINER? 1 YES 2 NO 1 Inpa	ITAL:	OTHER:	ome 5 🗆 Residence	6 Other (Sou	ncifu)		
PHYSICIAN:	27. MANNER OF DEATH 28e.	DATE OF INJURY (Month, Day, Year) 28b. Til	ME OF 28c. II	NJURY AT YORK?		E HOW INJURY OF	CCUREO	
BY	1 Natural 5 Pending 2 Accident Investigation			YES 2 NO				
COMPLETED	3 Sutcide 6 Could not be determined	PLACE OF INJURY — At home, ferm, building, etc. (Specify)	, street, fectory, of	Hen	281. LOCATION City or Tox	N (Street end Number vn, State)	er or Rural Ro	ute Number,
P. E.	29s. CERTIFIER (Check only	he best of my knowledge, death occur	rred at the ilme, da	te end placa, end due	to the cause(s)	end manner as at	ated.	
MO		beals of exemination end/or investigat						end manner es stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM	IBER	29d. OA	TE SIGNED (Month, Day, Year)
) BE	Mh/Sillas	S two		D 299	05			3 -95
5	38 NAME AND ABBRESS OF PERSON WHO COMPLE							
	GREGORIO M. BEL. 31. DATE FILEO (Morith, Day, Year) FFB 2.7 1995	REGISTRAR'S SIGNATURE	-CAWC	VV ICI,			v al	011
	FEB 27 1995	in Marchen Kardall						l



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Pages 1, 2, 3

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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RAT	RECT MS 3	E 2
TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending ph	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the but he filled within 72 hours after cheath with the State Deut of Health and Mental Muriene prior to burial, cremation, or removal	IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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MEDICAL

PHYSICIAN:

BY

COMPLETED

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29a. CERTIFIER

that initiated events resulting in deeth) LAST

PART II. Other significent cond

95 07786 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Louis R. Ehrensberger Feb. 27 1995 8:00 A 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYE 1 X M 2 - F 389-09-6683 907 Wisconsin March Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Ctr. Annapolis Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Annapolis 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 570 Bellerive Drive 21401 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cubsn, Mexican, Puerto Rican, etc.) 1 YES 2 MID Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Manager Office Supply Co. 17. FATHER'S NAME (First, Middle, Leet) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leonard BE Ehrensberger Elizabeth Hauptmann 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Kay Himmelmann 764 Windgate Drive Annapolis MD 21401 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 1 Cremation 3 ☐ Removal from State
4 ☐ Donation 8 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Metro Crematory B / 1 Catonsville. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. Barranco F.H. Severna Park MD 21146 23. PART I Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall IMMEDIATE CAUSE (Final th disease or condition resulting in death) CERTIFICATION Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury

a. RESDIRATORY FAILURE		Onset and Dea
DUE TO (OR AS A CONSEQUENCE OF):		
- EMPHYSEMA		DAYS
DUE TO (OR AS A-CONSEQUENCE OF): '		
· PNEUMONIA		
PUE TO (DR AS A CONSEQUENCE OF):		
. HIP TracTURE		weeks
itions contributing to deeth but not resulting in the underlying cause given in Part I.	24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE

ALZH	1 YES 2 7 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
DID TOBACCO USE CONT					
25. WAS CASE REFERRED TO MEDICAL	26. PLA	CE OF DEATH (Check	k only one)		
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient :	OTHE	R: Irsing Home 5 - Residence 1	B ☐ Other (Specify)	
27. MANNER OF DEATH	/ 28s. DATE DF INJURY (Month, Day, Year)	286. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCUP	RED

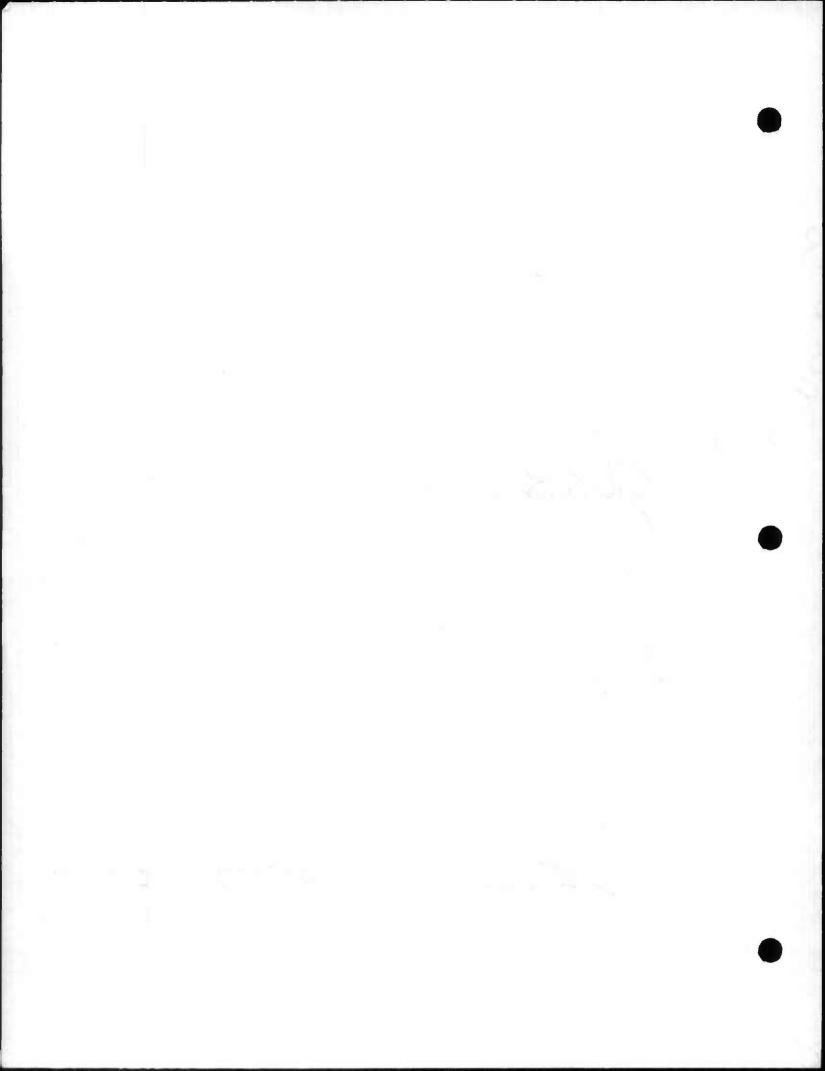
1 YES 2 NO Investigation Z Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office

28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide

JEC CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or I

		place	, and due to the cause(s) and manner as stated
96. SIGNATURE AND TITLE OF CERTIFIER	1	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

16	Class.	1235/3/	7-78-13
30. NAME AND ADDRESS OF PERSON WHO CO	DMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		Λ
CHARLES A	SEAGER 277	Peninsula FARM	RS. HENOUD
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE		
MAR 03 1995	In Studen Revolate		



DIVISION OF VITAL RECORDS, P.O. BOX 68760

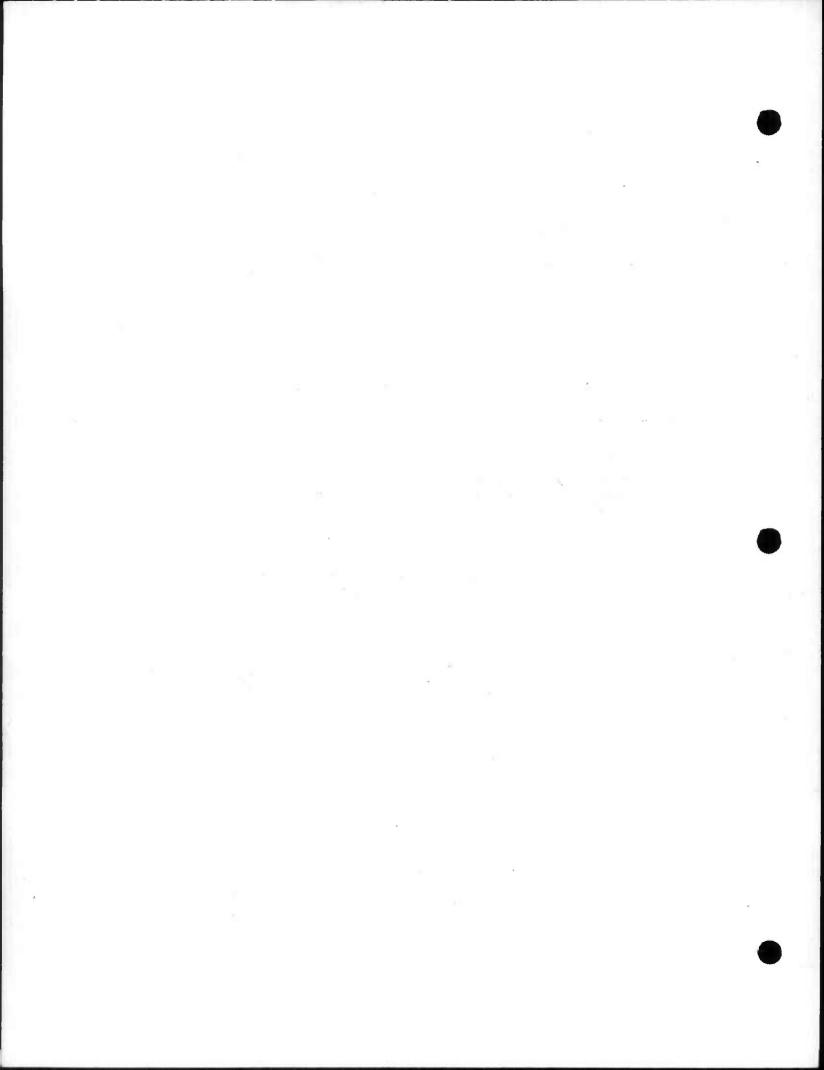
the interpretation of the control of
TO THE HUSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, nage 5 should be detacted for use as the burial-transfer nermit panes 1 2 servada
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

An	rended # 9a, 3	13/95, J	W,	Mo	nta	270	ier	ч	Co.			95	07787
	1 - STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR		OF H	EALTH	AND	MENTAL HY	GIENI	E		
	1. DECEDENT'S NAME (First, Middle, Last)					<u> </u>			2. DATE OF DE	_			3. TIME OF DEATH
	HARRY ECHO)LS							MONTH Feb	DM 2		95	1226 A M
	4. SOCIAL SECURITY NUMBER		E (in yrs. les		MONTHS I	YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BIR (Month, Day,	TH (bar)		8. BIRTI	IPLACE (State or Foreign
	577-18-9745 9a. FACILITY NAME (If not institution, give st	1 🖾 M 2 🗆 F	/9	YRS.					July 12	, 1		Virg	inia
Œ	Washington Adventi	HOS HOSPIES	Pita	cl	9b. CITY, T			ON OF DE	EATH			NTY OF C	
16	HEGIDEIVOE OF DECEDENT	ist mospitas	S-L-		Takon	na I	rark				Mon	tgom	ery
DIRECTOR	10a. STATE 10b. COUNTY			Į.	Y, TOWN OR								10d. INSIDE CITY
	Maryland Prince	e Georges		Ну	attsvi	-							1 TYES 2 NO
FUNERAL	1802 Amherst Road						ZIP CODI 2078:						WHAT COUNTRY?
N N	11. MARITAL STATUS	12. WAS DECEDENT EVER	INUS AR	MED	12 MB				IIC ORIGIN? (Spec	14 . 34 .		SA	
	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 N	10	If y	es, spe	cify Cuba	n, Maxica	n, Puarto Rican, e	tc.)	or No-	Blac Spec	E — American Indian, k, White, etc.
) BY	3 Widowed 4 Divorced	WW II						фоон				Spec	" White
E	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	16a. DE	Ve kind of	Work done duri se retired.)	JPATIO	N at of workin	19	16b. KIND	OF BUS	INESS/IN	DUSTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 5 +)			Super				II.S.	Gos	7. Pr	rint:	ing Office
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							IER'S NA	ME (First, Middle, I				ang office
BE (Harry L. Echols,	Sr.					Li1	lian	Haas				
2	19a. INFORMANT'S NAME (Type/Print) Adeline Echols								Route Number, City				
	20a. METHOD OF DISPOSITION					-		Нуа	ttsvill				
	1 X Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	wal from State	emetery, createry	matery or o	of Disposition (Interplace).	na1	™oor L Cen	nete:	ry 3/1 A	ec. LOC r 1 i	noto	City or To	wn, Stata irginia
	21. SIGNATURE OF PUNERAL SERVICE CIC	enessed 11		9	22. NA	ME AN	D ADDRES	S OF FA	outy Hines	$s-R^{\frac{1}{2}}$	nalo	li Fu	ineral Home
Ц	· Xhilip N	Grald			l ll Si	.800 .1ve) Nev ≥r Si	v Har oring	mpshire g. Marvl	Ave	enue 1 20	0904	
	23. PART I. Enter the diseesea, or contained abook, or heart feilure. L	omplications that ceuse on ist only one ceuse on	ed the de eech iine	eth. Do r	not enter th	e mod	ie of dyi	ng, suci	h aa cerdlec or	respir	atory an	reat,	Approximats interval Bstween
	IMMEDIATE CAUSE (Final disease or condition	Deens	CKEN	A	Acos	2	1	150	0.0		u. s	المأرا	One-4 and D45
1 1	resulting in death)	DUE TO (OR AS	A CONSEC	VENCE OF	P:	1.0.	7) 1		4 71	CVI	2010	V(1)	days
Z		STOOK	e w	in	16,0	Rt	- he	2m	pla	ia	1 av	nd	Months
FICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEC	UENCE OF	F):		F	1 PM	halsa	-			
윤	CAUSE (Disease or injury	DUE TO (OR AS	A CONSEC	CY C	-002	>							
臣	that initiated events resulting in death) LAST	24 MOC	6+	en	Sio	V	b						İ
E	PART ii Other elepiticent conditions												
MEDICAL	PART II. Other algnificent conditions (1) C-060 V66	A67C65	DY SC	SAL .	in the under	rlying	couse g	liven in	Part 1. 24a. W	AS AN A	MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Ē	ventsionles D	nefuncti	~(3	DO	2010	10	tus	Ute	.C/5 101	ES 2	NO		OF DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEA	TH YE	S \square NO		UNC	ERTAIN	<u></u>				1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				H (Check only				· 🗀				
YSI	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou	tpatient 3	□ DOA	OTHER:	Home	5 🗆 Ra	sidence	6 Other (Specif	y)			
	27. MANNER OF DEATH 1 ✓ Netural 5 ☐ Pending	(Month, Day, Year)		28b. TIM	URY	c. INJU WOR	IK?		28d. DEŞCRIBE	HOW IN	JURY OC	CURED	
ВУ	2 Accident Investigation	28s. PLACE OF INJUR	tY — At hor	ne, term, s		_	ES 2 _	NO	28f. LOCATION (Street or	od Mumbas	or Ount S	August March and August
TED	4 Homicide 6 Could not be detarmined	building, atc. (Sp	ecify)		,,	0.1102			City or Town,	State)	ia Number	or nurei r	oute Number,
COMPLET	29a. CERTIFIER Check only	IAN: To the best ot my kno	wledge, des	th occurre	ed at the time	, data s	and place,	and due	to the cause(a) ar	nd menr	or so atal	led.	
№		: On the beals of examinati) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	A. 00.	2 A A /	na.	~ M	DI	29c. LICE	NSE NUM	BER		29d. DATI	E SIGNED	(Month, Day, Year)
TO B	30. NAME AND ADDRESS OF PERSONAMIO	- / / / / /			- 1	?	6	24	573		▶ 6	1.5	LT-95

RHODE

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29 (INC. BUT) 31. DATE FILED (Month, Day, Year)
MAR 03 1995

JE MEDISTAR'S SCHATTER



DIVISION OF VITAL RECORDS, P.O. BOX 68760

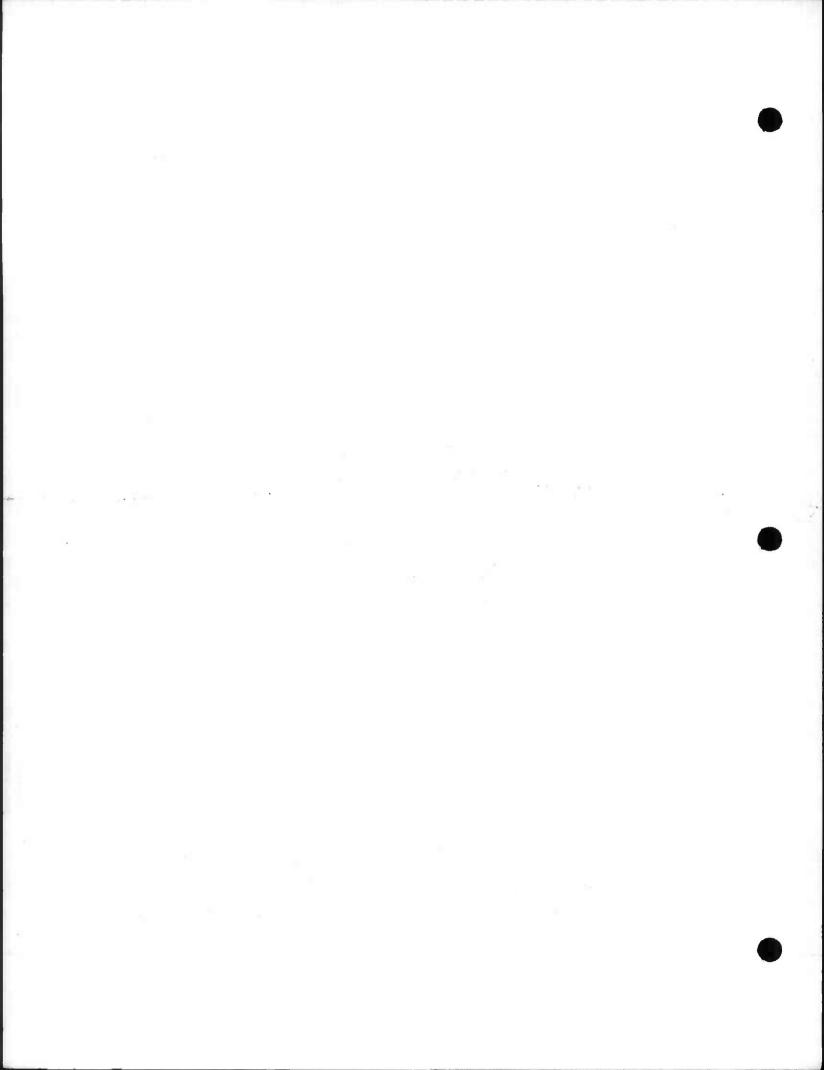
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the floath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complement float in the floath of the defeath of the size begr. of Health and Mental Hygiene prior to burial, crements in removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the marked is marked, or item 23 shows any injury, or other traumatic event.

STATE OF MARYLAND / DEPARTMENT OF H	EALTH AND	MENTAL I	HYGIENE
CERTIFICATE OF	DEATH		REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Louis Alvin	Everson				February	21,1995	7:41 P M
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	S. BIRT	HPLACE (State or Foreign
	230 92 8402 9a. FACILITY NAME (If not institution, give	1 🔀 M 2 🗆 F	38 YRS.	DAYS	R LOCATION OF DE	April 19,1	.956 V	irginia
DIRECTOR	Montgomery Gener			Olney			Montgom	
EC	10a. STATE 10b. COUN	TY	10c. CITY, 1	TOWN OR LOCAT	ION			10d. INSIDE CITY
PIG	Maryland Mo:	ntgomery	Asi	hton				LIMITS?
	10a. STREET AND NUMBER				. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	17307 Avenleig	h Drive			20861		United	States
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			IC ORIGIN? (Specify Yes	or No- 14. RAC	E — American Indian, ck, White, etc.
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 NO Specify	, Puarto Rican, etc.)		W: Black
	15. DECEDENT'S ED	I I I I I I I I I I I I I I I I I I I	18e. DECEDENT'S US	1141 000010471		[
COMPLETED	(Specify only highest grad	de completed)	(Give kind of work life. Do NOT use n	k done during mo		166. KIND OF BUS	SINESS/INDUSTRY	
PLI	12	College (1-4 or 5+) 5+	Account	ant		Aero-Spa	ce Manuf	acturing
ON I	17. FATHER'S NAME (First, Middle, Last)		nocount	arre	18. MOTHER'S NAM	ME (First, Middle, Maiden		accurring
BE C	Percy Ev	erson Sr.				Mattie H	Parham	
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AT	ODRESS (Street a	nd Number or Rural R	oute Number, City or Town	n, State, Zip Code)	
-	Mary Henson		626 Ke	nsingto	n Pl.,N.	E.,Washing	gton, D.(20011
	20a. METHOD OF DISPOSITION 1 ☑ Burial 2 □ Crymation 3 □ Res	moval from Stata 20b. F	PLACE AND DATE OF I tery, crematory or other Lincol	DISPOSITION (Na	me of	1	CATION — City or T	
	4 Donation 5 Other (Specifical Street, Specifical Street, Specifical Street, Specifical Street, Specifical Spe	ICENSEE /	c. Lincol		D ADDRESS OF FAC		rentwood	, MD.
	SANG	07/-	11			al Service	. Inc.	
_	yarues		in	7400	Georgia A	Ave. N.W.,	Washing	ton, D.C.
		 List only one cause on each 	ch line.				ratory arrest,	Approximete Interval Between
_	IMMEDIATE CAUSE (Final disease of condition	MoLal	tic Re	100	(1)	CEA		Onset and Death
	resulting in death)	e. DUE/TO (OR AS A	CONSEQUENCE OF:	Crac	CIII	1 CAL		Ly Epra.
-	_	on Ev	1/A					, , , , , , , , , , , , , , , , , , ,
5	Sequentially list conditions, if any, leading to immediate	U	CONSEQUENCE OF):	-/				
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	1 (assi,	re Ha	les.				
E	that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):					
CERTIFICATION		d						
AL	PART II. Other significant condition	ns contributing to death bu	t not resulting in t	tha underlying	cause given in f	Part I. 24s. WAS AN PERFOR		WERE AUTOPSY FINDINGS MAILABLE PINOR TO
PHYSICIAN: MEDIC						1 🖂 YES 2	The state of the s	OF DEATH?
M			1015 St. 1 100 St.		,		"	1 - YES 2 - NO
Ä	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL				UNCERTAIN			
C	EXAMINER?	HOSPITAL:		THER:		HIDE-CONTROL TWO PROPERTY.		
448	1 YES 2 NO 27. MANNER OF DEATH	1 Dispetient 2 ER/Outpet	28b. TIME O		5 - Hesidence 6	28sl. DESCRIBE HOW II	WARRY OCCUPIED	
	1 🕅 Ratural 5 🗌 Pending	(Morth, Day, Wer)	MJUR	Y WO	RKT	288. DESCRIBE ROW S	NJUNY OCCUMED	
Э ВУ	2 Accident Investigation 3 Suicide 8 Could not be	25s, PLACE OF BUILDRY -	At frome, farm, atre			281. LOCATION /Street a	and Mumber or Rural	Route Number
COMPLETED	4 Mamicide determined	building, etc. (Specify	rt.			City or Yown, State)		
PE	294. CERTIFIER 1 X CERTIFYING PHYS	SICIAN: To the best of my artistic	ine, death occurred a	rt the time, date	and pleca, end dua t	to the cause(a) and men	nner aa stated.	
O.	MEDICAL EXAMIN	IER: On the basis of examination	and/or investigation, i	in my opinion, d	eath occured at the t	lme, data and place, en	d due to the ceuse(a) and menner as stated.
BE C	26. SIGNATURE AND TITLE OF CENTIFIE	in 9	_		291. LICENSE NUM	вея	29d. DATE SIGNED	(Month, Day, Year)
TO B	MARIN	11//			1857		> 2/2	2/95
	30. NAME AND ADDRESS OF PERSON W	LETED CAUSE OF DEAT			1.0		MAN N	() / .
	31. DATE FILED (Month) -Qay, Year)	3. REĞİŞZÜZÜZÜ SIÇMAT	THE GOL	ACG14	Avenu	W.M.M	NKI IA - CT	- 20060
	FEB 27 1995	REGISTRAR'S SIGNAT	Cardall			f		ļ
	1 20							



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ВУ

COMPLETED

BE

2

3 Suicide

29b. SIGNATURE

31. DATE FILED (MOOR) PEB

4 Homicide

									95	0	7789
	1 - STATE REGISTRAR	STATE OF F			RTMENT OF	HEALTH AND F DEATH	MEN	ITAL HYGIEN			
	t. DECEDENT'S NAME (First, Middle, Last)			-	- 1		2. D	DATE OF DEATH			3. TIME OF DEATH
	Joseph William			-	-orbs	2-	l land	2 2 4	W	95	01.30 H
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las.	st birthday)			7. D	ATE OF BIRTH		8. BIRTHPL	LACE (State or Foreign
	220-01-8967	1 M 2 □ F	87	YRS.	MONTHS DAYS	HOURS MIN.	8	Month, Day, Year)		Country)	NY
	9a. FACILITY NAME (If not institution, give st				9b. CITY, TOW	N OR LOCATION OF D	DEATH		9c. COUNT	TY OF DEA	Т Н
DIRECTOR	PENINSULA REGIONA	AL MEDICA	AL CENTE	R	SAL	ISBURY			W	ICOM	ICO
E	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Y		T 10c. Cr	TY, TOWN OR LOC	ATION				1.2	
HI	20/10/1	Worceste	r	100. 01.	Snow						IOd. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			Ь.		101. ZIP CODE			T to CITIZ		TAT COUNTRY?
RA	7903 Public La	nding R	D		1	21863			10g. CITIZI		
FUNERAL	11. MARITAL STATUS			MED	T 13 WAS D	Z 1003 ECENDENT OF HISPA	ANIC OR	MANAGE PROPERTY Voc	Table I	US	
	t Never Married 2 X Married	FORCES? 1	T EVER IN U.S. ARI	10	It yes, a	specify Cuban, Mexic	can, Pua	irto Rican, atc.)	Of NO-		- American Indian, Whita, atc.
BY	3 Widowed 4 Divorced	IF TES, CHYL Y	AR UN DATES		1 11	ES 2X NO Speci	My:			Specify:	white
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION COMPLETE	16a. DE	CEDENT'S	S USUAL OCCUPAT	TION		16b. KIND OF BUS	SINESS/INDU	STRY	
E	Elementery/Secondary (0-12)	College (1-4 or 5 +	+)		work done during nuse retired.)						
MP	9		PI	lumb	er & St	eamfitter		Plumbir	ng		
00	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N	IAME (FI	irst, Middle, Malden	Surname)		
BE (Richard Forbes					Geor	·gea	anna Bro	own		
10	19a. INFORMANT'S NAME (Type/Print)					t and Number or Rural					
F	Iva P. Forbes			7903	Public	Landing	RE	Snow	Hill,	MD :	21863
	20a, METHOD OF DISPOSITION 1 Description 2 Cremation 3 Remo	oval from Stata	20b. PLACE A		OF DISPOSITION (Name of	1 0	DATE 20c. LO	CATION — CI	ity or Town	n, State
	4 Donation 5 Other (Specify)		Everg	reer	Cemet	ery	3/1	/95 Be	erlin,	MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE				AND ADDRESS OF FA	ACILITY		77-		
	1. Siel Bu	ulalen			108	Williams	et	Burbag	Je Fui	nerai	Home
	23. PART I. Enter the diseases, or c	:Drapligations the	it caused tha da	ath. Do	not antar tha m	node of dying, su	ch as (cardiac pr raspi	retory arre	Z 101	Approximate
	snock, or heart failure.	Liat only Dna cau	ise Dn aach lina	l.				The Property of the Party of th		,	Interval Batween
- 1	IMMEDIATE CAUSE (Final disease or condition	Δ.	.00	· . t.	- E-						Onset and Death
H	reaulting in death)	DUE TO	(OR AS A CONSEC	DUENCE C	DED:						2 days
-			(• 7-						
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	OUENCE O	NF):						
ZAT	cause. Entar UNDERLYING										İ
ĬĘ	CAUSE (Disesse or Injury that initisted events	DUE TO	(OR AS A CONSEC	DUENCE O	IF):						
F	resulting in death) LAST	d									
ᄗ	Darry II Other cignificant condition										
PHYSICIAN: MEDICAL	PART II. Other eignificant conditions	1		esuiting	in the underlyi	ng cause given in	1 Part i	i. 24s. WAS AN A PERFOR		A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
Ö	condestine Me	eart t	ailme					1 - YES 2	NO		OMPLETION OF CAUSE OF DEATH?
ME	myocardial	interest								1	YES 2 NO
ä	DID TOBACCO USE CONTR	EIBUTE TO CA	USE OF DEAT	JH Y	ES NO J	UNCERTAI	IN 🗆]			
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSBITAL:	26. PLAC	E OF DEA	OTHER	*)					
YSI	t YES 2 NO	1 Inpatient 2		□ DOA	OTHER: 4 Nursing Ho	ome 5 🗆 Residence	6 □ 0	Other (Specify)			
H	27. MANNER OF DEATH	28e. DATE OF (Month, Da		28b. TIM		NJURY AT YORK?	28d.	DESCRIBE HOW IN	JURY OCCU	RED	

d.									
Itiona	contributing	to death	but not	resuiting	in tha	undariying	cauae	given in Part i.	_

AS CASE REFERRED TO MEDICAL		ATH (Check only one)
EXAMINER?	HOSBITAL: 1 Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Home 5 Residence 6

27. MANNER OF DEATH Natural 5 Pending investigation 2 Accident

28 1995

28e. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At home, term, street, lactory, offica building, atc. (Specify) 6 Could not be detarmined

DOA	4 🗆 Nu	rsing Home 5 - Residence	6 Other (Specify)
28b. TIR IN	ME OF JURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEȘCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

(Check only	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and dua to the cause(s) and manner as stated.
one)	2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the co

Z MEDICAL EXAMINER: On the besis of examination and/or investigation	on, in my opinion, death occured at the time, date end piece, and dua to the cause(s) and manner as stated.
AND TITLE OF CENTERS	

3085

Carroll St.

30. NAME A	ND ADDRESS OF	PERSON WHO	COMPLETED	CAUSE OF DEA	TH (ITEM 27) (Type, Print)
9	harles	B. 1	silvia	Jr	mo

V	ia	15	(m)	
32.	REGIST	BAR'S SIGN	ATURE 0	

MD21801

DHMH-16 Rev 1/89

5

Salisbury,

•

P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 STATE	STATE OF M							MENTA	L HYGIEN	IE			
	REGISTRAR		С	ERTIF	ICAT	E OF	DEAT	ГН		REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last)			-					2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DEATH	
	Gladys Alda			-)e.	tch.	ev		61	ruary 2			1220	M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la:	st birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH	****	6. BIRTHE	LACE (State or Foreign	ın
	227-24-1154 9e. FACILITY NAME (# not institution, give st	1 🗆 M 2 😿 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	May	th, Day, Year)		Mar	yland	
or						Y, TOWN C			EATH			ITY OF DE		
DIRECTOR	PENINSULA REGIONA	AL MEDICA	L CENTE	ER		SALI	SBUR	Y			1	VICON	ICO	
S	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,		T 100 CIT	V TOWN	OR LOCAT	2004							
<u>~</u>	Winning a see	es alle		-	-							- 1	10d. INSIDE CITY LIMITS?	
		mack		Nei	V CI	urc	h						1 TYES 2 NO	
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODI	E			10g. CITt	ZEN OF W	HAT COUNTRY?	
Ш	3784 Davis Rd					2	3415	5			Uni	ted	State	
5	11. MARITAL STATUS	12. WAS DECEDENT			13.				NIC ORIGI	N? (Specify Yes		14 BACE	- American Indian	
	1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA		NO		tt yes, spe	city Cube	in, Mexica	in, Puerto	Rican, atc.)		Black,	White, atc.	
BY	3 Widowed 4 Divorced		TOT DATES			I L IES	AL NO	Specif	у.		1	Bia	ck.	
G	15. DECEDENT'S EQU		16a. DE	CEOENT'S	USUAL C	CCUPATIO	ON .		16	b. KIND OF BU	SINESS/IND			_
H	(Specify only highest grade Elementary/Secondary (0-12)		(G	ive kind of v	vork done e retired.)	during mo	st of working	ng	100					
7	7th	College (1-4 or 5+)	Tue 7	orei		Co	nnin	A CT		F- oto	20.00			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	-	- Sil 1	701 61	_	3.				Facte				
	22.6 2 2 2						18. MOT	HER'S NA	ME (First,	Middle, Maiden	Sumame)			
BE		ene					Jak	eie.	Br	ought	Tons.			
5	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILINO	ADDRES	S (Street a	nd Number	or Rural	Route Nun	ber, City or Tow	n, State, Zip	Code)		
F	Norman Fletch	er	7	5784	Day	ria	RD.	Nev	y Ch	mrch.	W-	234	15	
	20s. METHOD OF DISPOSITION	7.7	20b. PLACE			-			DAT		CATION -			
	1 Buriet 2 Cremation 3 Remo	oval from State	Tabe						1					
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGEE	1-00	and the	1	-St	0 40005	00.05.54	Du 1771	TIGIT	nton	III V	3 -	
		LITOLL			Sa	NAME AN	e Fi	mei		Home	P.O.	Box	16	
	1) 0-()	0	1-	de	-Me					-2341			10	
	23. PART i. Enter the diseeses, or c	omplications that	caused the de	eth do n		the mo	de of dvi	ng. euc	h es cer	diec or reep	ratory err	est.	Approximate	_
	anock, or heart failure. I	Liet only one ceus	e on eech lige				72						interval Betwe	
	iMMEDIATE CAUSE (Finel disease or condition												Onset and De	eath
	recuiting in death)	>6h	OR AS A CONSE										13day	5
		-	A										21	
Z	Sequentially list conditions.	1) eh	OR AS A CONSE	cron	-								1 Sday	5
2	if sny, leading to immediate	DUE TO (C	R AS A CONSE	OUENCE OF):									
CA	cause. Enter UNDERLYING	: Sein	Nec.	Disc	cch	25							Soday	<
<u>E</u>	CAUSE (Disease or injury that initiated events	DUE TO (C	R AS A CONSE	OUENCE OF):								1	2
CERTIFICATION	reaulting in deeth) LAST	arol.	brown	Sil	V-C	Di-	S 4 2	0.5						
CE			0,000	360	,			2						
	PART II. Other significent conditions	s contributing to d	eeth but not i	recuiting i	n the u	nderlying	ceuse g	lven in	Part i.	24a. WAS AN			WERE AUTOPSY FINDIN	NGS
2	Congestive 18	such Fail	1100.							PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSI	E
유	11 0 :									1 🗌 YES 2	KNO		OF DEATH?	
Σ	Hypertems.												TO YES 2 NO	
PHYSICIAN: MEDICA	DID TOBACCO USE CONTR	RIBUTE TO CAL	SE OF DEA	TH YE	S	NO 🗆	UNC	ERTAI	N				,	
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT										
S	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHEI		5 🗆 Ra	sidence	6 🗆 Othe	er (Specify)				
=	27. MANNER OF DEATH	28s. DATE OF IP	JURY	26b. TIME	OF	28c. INJU	JRY AT			SCRIBE HOW I	NJURY OCC	URED		_
	1 Natural 5 Pending	WORTH, Day	Year)	INJI	URY M	1 T Y	RK? ES 2	NO.						
B	2 Accident Investigation 3 Suictde P Could set be	200. PLACE OF	INJURY At bo	me term e	traat tan	_		-	201 1 07	ATION (Or	- 4 14 Cl 2 C			
8	8 Could not be	building, at	c. (Specify)	,, .		iory, orrica			City	or Town, State)	ina Number	or Hunai Ho	ute Number,	
ᆸ				-:										
COMPLET	29a. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of m	y knowledge, de	ath occurre	d at the t	lme, data	and placa,	and dua	to the ca	use(a) and mar	mer as atate	d.		
2	one) 2 MEOICAL EXAMINER												and manner as stated	d.
<u>ا ج</u>						-						. ,		
	205 MONATURE BAID TITLE OF COMPANY													
	296 MONATURE AND TITLE OF CERTIFIER	The (Don				29c, LICE	110	-		29d. DATE	SIGNED (Monto, Day, Year)	
TO BE	296 NONATURE AND TITLE OF CENTIFIER 30. NAME AND ADDRESS OF PERSON WHO	let	D.				29c. LICE	110	37	8	29d. DATE	SIGNED (Monto, Day, Year)	

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

whis Danielan Randon

560 RWRE 31. DATE FILED (Month, Day, Year)

1995

DHMH-16 Rav 1/89

1.1-

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7 .-

menda Et f di na

THE DEER KIND

a come gallada

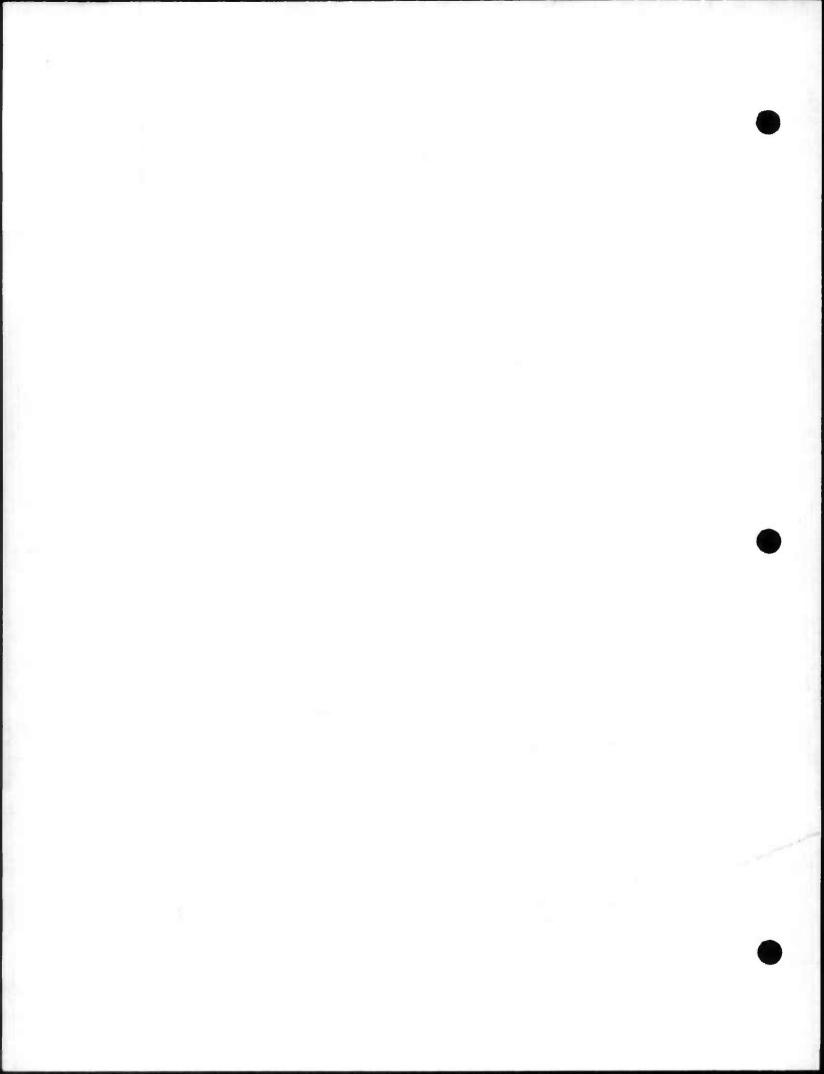
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician.
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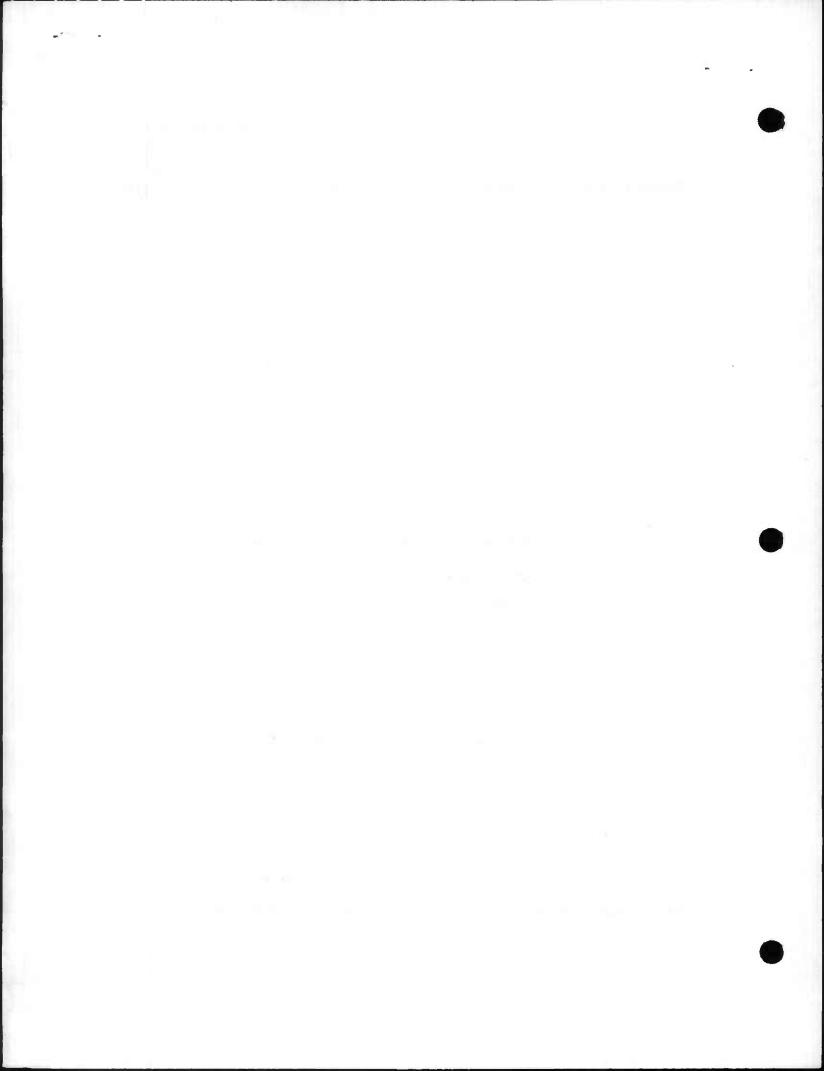
STATE	OF MARYLAND / DEPARTMENT O		MENTAL HYGIENE
	CERTIFICATE (OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE		
8	1. DECEDENT'S NAME (First, Middig, Last)	Alice	Fleagl.	2	2. DATE OF DEATH DAY	YEAR OF	3. TIME OF DEATH
1	173-03-2212	SEX 6. AGE (In you le	YRS. MONTHS	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-8-1910	Country)	esboro, PA
TOR	99. FACILITY NAME (If not institution, give street Washington County RESIDENCE OF DECEDENT			gerstown	DEATH	Washing	
DIRECTOR	MD Washi	ngton	Smithst				IOd. INSIDE CITY LIMITS? I YES 2 X NO
FUNERAL	14046 Edgemont RD			10f. ZIP CODE 21783		109. CITIZEN OF WH	AT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 NI IF YES, GIVE WAR OR DATES	NO	WAS DECENDENT OF HISP, if yes, specify Cuben, Mexi I YES 2 XND Spec		Black, Specify:	- American Indian, While, etc. Thite
COMPLETED		mpleted) (G College (1-4 or 5+)	ECEDENT'S USUAL O Give kind of work done s. Do NOT use retired.)	CCUPATION during most of working	16b. KIND OF BUSIN		111100
OMP	9 17. FATHER'S NAME (First, Middle, Lest)	La	borer	16. MOTHER'S N	Clothing		
BE C	Clarence Sharrah				Bowman		
ք	19a. INFORMANT'S NAME (Type/Print) Terry Fleagle				Moute Number, City or Town, mithsburg, N		
	20a. METHOD OF DISPOSITION 1X Nauriel 2 Cremation 3X Nemoval 4 Donalion 5 Other (Specify)	I from State 20b. PLACE completry, cra	AND DATE OF DISPOS prietory of other place) Daugh Chu	ITION (Name of	DATE 20c LOCA	ington Town	wnship
	21. SIGNATURE OF FUNERAL SERVICE LICENT		22.	NAME AND ADDRESS OF F	Grove Fu	uneral Ho	me, inc.
	23. PART I. Enter the diseases, or com	pplicetions that coused the det only one couse on each line	eeth. Do not enter	the mode of dying, su	ST Waynesbo	oro PA	17268 Approximate
	iMMEDIATE CAUSE (Finel disease or condition resulting in desth)	S traffic	QUENCE OF:	· left	henspher	L	Interval Between Onset and Death
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	QUENCE OF):	V	· ·		
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	QUENCE OF):				
4	PART II. Other algnificant conditions conditions	ontributing to deeth but not r	reculting in the un	deriying ceuse given is	Part I. 24s. WAS AN AL	ED? A	PERE AUTOPSY FINDINGS WAILABLE PRIOR TO
PHYSICIAN: MEDIC					1 TES 2 (D	OMPLETION OF CAUSE F DEATH?
HAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	TH YES 1		N 🗆		
IYSIC	111	OSPYAL: Impatient 2 ER/Outpatient 3		ing Home 5 - Residence	6 Other (Specify)		
ВУ РЬ	1 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW INJ	URY OCCURED	
	3 Suicide 6 Could not be detarmined	28a. PLACE OF INJURY — At ho building, etc. (Specify)	ome, farm, street, fact	ory, office	281. LOCATION (Street and City or Town, Stete)	Number or Rural Rou	te Number,
COMPLETED		N: To the best of my knowledge, de On the basis of axemination and/or					nd manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER KOLL HELL	MB Perional	2 Physic	en 29c. LICENSE NU		Ped. DATE SIGNED (M	
	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print) Po Yorm	ac Ave.	Hagevsto	iwn	
	FEB 2 2 1995 Julia	32. REGISTRAR'S SIGNATURE			J		



	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
RAR	CERTIFICATE OF DEATH	REG. NO.

•	•	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGIEN			
		t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH
•		James	Samuel	1	Freema	n	February	.26 19	YEAR	9:25 AM M
.00		4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			PLACE (State or Foreign
모		217-30-8535	1 X M 2 □ F 9	2 YRS.	MONTHS DAYS	HOURS MIN.	Nov. 20,	1902		rvland
3 should	~	9e. FACILITY NAME (If not institution, give str			9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUNT		
2,	DIRECTOR	Memorial Hospital	at Easton		Easto	n		Ta1	bot	
Jes 1.	EC	10e. STATE 10b. COUNTY		t0c. CIT	Y, TOWN OR LOCA	TION		1000		10d. INSIDE CITY
بر م	DIE	Maryland Talbo	+	E.	aston					LIMITS?
permit. Pages	AL	10a. STREET AND NUMBER	1,			I. ZIP CODE		10g. CITIZE	N OF W	THAT COUNTRY?
ışı	FUNERAL	P.O. Box 400			2	1629		USA	4	
020 physician. burial-trar	5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN 1 FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	HC ORIGIN? (Specify Yes		4. RACE	- American Indian, White, etc.
Pe Pe	ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES		25 NO Specify			Specifi	
1215-0 r attending use as the	<u>B</u>	15. DECEDENT'S EDUC	ATION	16e. DECEDENT'S	USUAL OCCUPATION	OM.	18b. KIND OF BUS	Parison miles		ack
212 or use	ET	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during mo	ast of working	IGE. KIND OF BU	SINESS/INDU	SIMT	
AND 2. the hospital of detached for once.	AP	3		ra rm]	and		Farm			
AND 2 the hospital detached to once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)		F 6: 1 - 111.		18. MOTHER'S NA	ME (First, Middle, Maiden			
d by d by	BE (Isiah Freema	n			Anni	e Wilso	n		
MARYLAND 21215-0020 retained by the hospital or attending physic S should be detached for use as the burial notified at once.	2	19e. INFORMANT'S NAME (Type/Print)	-	19b. MAILING	ADDRESS (Street e	and Number or Rural P	Route Number, City or Tow		ode)	
F, N y be re sage 5	_		nks	4821	Old Tr	appe Ro	ad Trapp	e. Ma	rv	land21673
ALTIMORE, death. Page 6 may be funeral director, page examiner must be		20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	val from State cemet	ery, crematory or o	OF DISPOSITION (Ne	ame of		CATION — CH		
Age direct		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	Pa	aradis	e Cemet	ery	3/4 Tra	ppe.N	<u>lar</u>	vland
ALTIM death. Page tuneral direct. t. examiner n			0 0				eral Home			
0 - 0		Adulle	C. Du	mx	510 W	ashingt	on St C	ambri	da	e. Md.2161
urs in le		23. PART I Enter the diseases, or co	emplications that ceused t ist only one ceuse on eac	the death Do r	not enter the mo	de of dying, aucl	h aa cardlec or reepl	ratory arres	t,	Approximete Interval Between
		IMMEDIATE CAUSE (Finel disease or condition								Onset and Death
ith defe		resulting In death)	Arterio Scl	erotic	Cardiova	scular D	isease			Years
B 2 . 8	_				F):					
OX 6876 be executed sician and conficial to burial, traumatic ex	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate	Hypertension Due to (or as a c	ONSEQUENCE OF						Years
BO) ate be sysiciar prior	S		Atrial Fibr							
- 5 4 5 E	E	that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF	F):					
D = 8 + 6	EB	resulting in death) LAST								
0 2 5 2	AL C	PART II. Other algnificant conditions	contributing to death but	not resulting	n the underlying	ceuse given in	Part I. 24s. WAS AN	ALITOPSY	74h	WERE AUTOPSY FINDINGS
- 2 2 2	2		alemia				PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE
requires that een signed by of Health are shows any	MEDIC/	iny ivos	atemia				1 YES 2	X) NO		OF DEATH?
sh of sh	2	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YE	SINO	UNCERTAIN	<u></u>			1 TYES 2 X NO
I I AL I: The law cate has b State Dept. Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	28		'H (Check only one)		. 4.			
VIII SIAN: 1 rufficat he Stat	Sign		HOSPITAL: t ☐ Inpatient 2 🙀 ER/Outpati	lent 3 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residence	6 Other (Specify)			
9 9 7	E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIM		URY AT RK?	28d. DESCRIBE HOW II	NJURY OCCU	RED	
NG PHYS frer this cath with	B	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 1	rES 2 NO				
D 5 4 5 L		3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify	- At home, farm, a	treet, lectory, office		261. LOCATION (Street e City or Town, State)	nd Number or	Aural Ro	oute Number,
ON ATTENDING OR ATTENDING DIRECTOR: After hours after death Item 28 is ma	COMPLETED									
4 7 7 E	릴		AN: To the best of my knowled							
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: H	S I	PICAL EXAMINER	On the basis of examination s	end/or investigation	n, in my opinion, d	eath occured at the	lime, date end place, en	d due to the o	:ause(e)	end manner ee stated.
HE HE HE M	BE	296. SIGNATURE AND TITLE OF CERTIFIED	h m	n		29c. LICENSE NUM	IBER	29d. DATE S	IGNED (Month, Day, Year)
5 5 3 W	2	Layer				D44282		Fe	eb.	27 1995
		NAME AND ADDRESS OF PERSON WHO								
		Claude Koprowski M	D. 219 S.	Washir	igton St	. Eastor	n Md. 2	1601		
		MAR 0 2 1995	32. REGISTRAR'S SIGNAT	arda II.						
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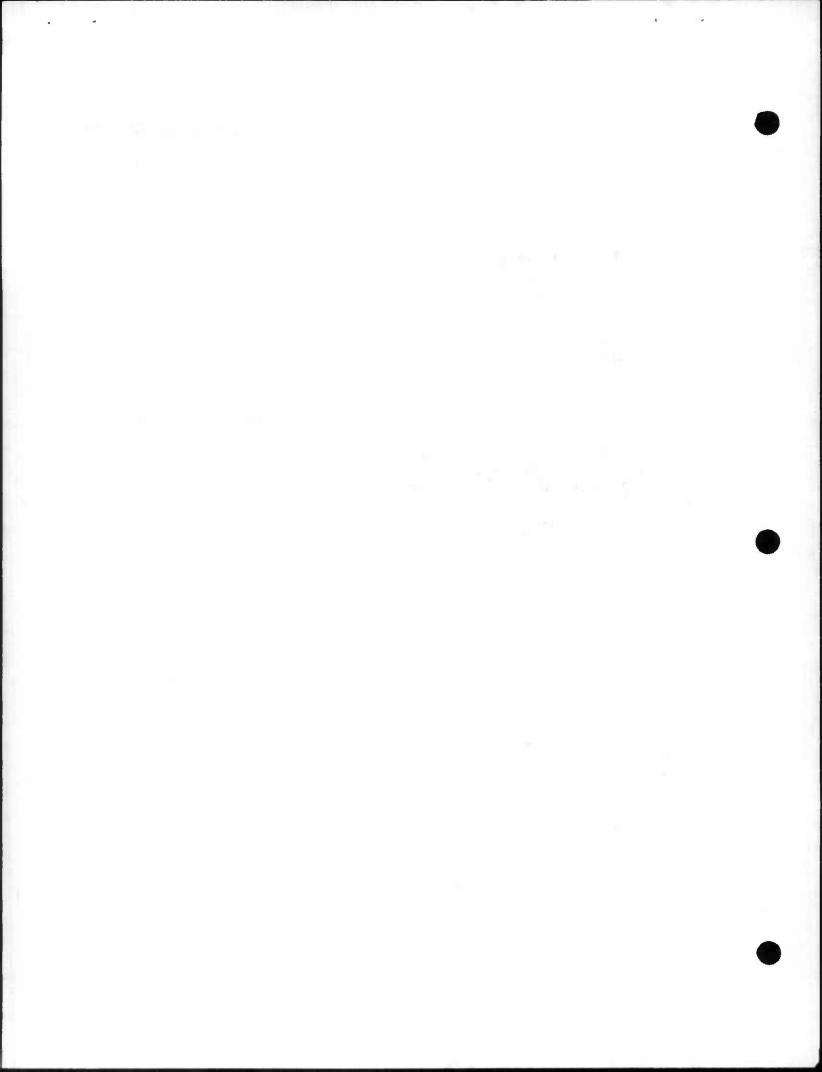


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HYSICIAN: The law requires that the death certificate be executed withhin—54 hours after death. Page 6 may be retained by the hospital or attending physician. It is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 1. 2, 3 should be detached for use as the burial-traumatic event, the medical examiner must be notified at once.
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			C	ERTIF	CATE O	F DEATH	F	REG. NO.					
	1. DECEOENT'S NAME (First,	Middle, Last)						2. DATE OF	DEATH			3. TIME OF D	EATH	٦
	EDWARD	AU	GUST		F	ricke		Febru			YEAR	5:40	р	u I
ш	4. SOCIAL SECURITY NUMB	ER	5. SEX 6.	AGE (In yrs. la		IF UNDER I YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	<u> </u>	6. BIRTI	HPLACE (State o		\dashv
- 1	158-14-5436		1 [X] M 2 □ F	90	YRS.	MONTHS DAY	HOURS MIN.	OCT 4		0/4	NEU	JERSE	v	
	9e. FACILITY NAME (If not in:	stitution, give	street and number)			9b. CITY. TOW	N OR LOCATION OF D		, 1)	Y	JNTY OF C		ı	\dashv
۳	MEMORIAL HOS									30.000				п
운	RESIDENCE OF DEC					EAS	TON				TAL	BOT		4
DIRECTOR	10a. STATE	10b. COUNT	Υ		10c. CIT	, TOWN OR LO	CATION					10d. INSIDE C	YTY	1
	MARYLAND	DORC	HESTER		l	HURLOC	K					LIMITS?	EYNO.	
	10e. STREET AND NUMBER						10f. ZIP CODE		-	10m, CIT	TIZEN OF Y	WHAT COUNTRY		\dashv
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E	1 Never Merried 2 X	Merried	FORCES? 1	YES 2 X	NO	If yes,	specify Cuben, Mexic	an, Puerto Rica	n, etc.)	01 140-	Blac	k, White, atc.	naien,	н
B	3 Widowed 4 Divo	rced	IF YES, GIVE WAR	OR DATES		1 U Y	ES 2 X NO Speci	ily:			Spec	"y: WHIT	E	-1
		EDENT'S EDU		18e. Di	ECEDENT'S	USUAL OCCUPA	TION	16b. KIR	ND OF BUS	NESS/IN	DUSTRY			\dashv
	(Specify only Elementary/Secondery (0-	highest grade	College (1-4 or 5+)	(0	live kind of v	ork done during e retired.)	most of working							1
ᆲ	10	/	College (1-4 b) 5 +)	OW	NER/C	PERATO	R		RES	TAUR	ANT			-
COMPLET	17. FATHER'S NAME (First, Mi	ddle, Last)					16. MOTHER'S NA	AME (First Midd			11111			-
	JOHN FRICKE							ETTE S						
8	19e. INFORMANT'S NAME (7)	me/Print)		10	h MAII INC	ADDRESS (Standards)	at end Number or Rural			~				4
2	MADGE N. FRI						S WHARF R					31673		1
1	20e. METHOD OF DISPOSITI			100 01 105								21643		4
	1 X Buriel 2 Crematio	n 3 🗆 Rem	ioval from State	COMPLACE	AND DATE C	FDISPOSITION	CEMETERY		20c. LO					J
	4 Donation 5 Other	-	CENGED 1	7/	WASI		AND ADDRESS OF F		HUKI	JUCK,	, MAI	RYLAND		4
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	1 ser	Melo	lat-	que	er	106	MAIN STRE	ET. EA	ST N	EW M	ARKE	r. MD 2	1631	
CERTIFICATION	Approximate interval Between Onset and Death Approximate interval Between Onset and Death Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events													
1	resulting in death) LAST		d											
	PART it. Other algnificer	nt condition	as contributing to de	eth but not	resulting i	n the underly	ing ceuse given in	Part I 24	. WAS AN	Alimpey	245	. WERE AUTOPS	V ENDINO	+
DICA						and and any	ing codes given in	144	PERFOR		240	AVAILABLE PRI	OR TO	1
								10	YES 2	X NO		OF DEATH?	A CAUSE	Ī
Σ	DID TODA CCO III	CE CO. IT	DIDLITE TO CALL		T11 >4		A					1 YES 2	NO	1
Ž	DID TOBACCO US		KIBUTE TO CAUS					иПТ						
2	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			H (Check only or OTHER:	(6)							+
PHYSICIAN	1 TYES 2 NO		1 Inpatient 2 E		_		orne 5 🗆 Residence	6 Other (Sp	ecify)					╛
5	27. MANNER OF DEATH 1 🛣 Natural 5 🗍 (Pending	28e. OATE OF IN. (Month, Day,		28b. TIMI	JRY	NJURY AT WORK?	28d. OESCRI	BE HOW I	NJURY OC	CUREO			
6		nvestigation					YES 2 NO							
2		Could not be	28s. PLACE OF II building, etc	NJURY — At ho . (Specify)	ome, farm, s	treet, factory, of	fice	28f. LOCATIO City or To	N (Street a	nd Numbe	r or Rural I	Route Number,		
PLE IE														
4	(Check only	FYING PHYS	ICIAN: To the best of my	knowledge, de	eath occurre	d at the time, d	ite end place, and due	o to the cause(e	end men	ner se sta	ited.			٦
5	one) 2 MEDI	CAL EXAMINE	R: On the basis of exam	ination end/or	Investigation	n, in my opinion	, death occured at the	time, date and	placa, and	d due to t	he ceuse(s) end menner e	e stated.	1
3	296. SIGNATURE AND TITLE	GE CERTIFIE	R				29c. LICENSE NU	MBER		29d. DAT	TE SIGNED	(Month, Day, Ye	er)	4
ון מ	2	3					7247	69		17	124	19.		
2	30. NAME AND ADDRESS OF	PERSON WI	O COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type,	Print)	0	3			104	13		4
	Littomas	Divil	AM &	P		x & ZZZ	& cta	· M	0 3	160	7 }			
	31. DATE FILED (Month, Day, 1		32 REGISTRAR'S	SIGNATURE		1 600	27100)			/			4
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MEDICAL EXAMINER

296. SIGNATURE AND TITLE/OF CHATTE

30. NAME AND ADDRESS OF PERSON

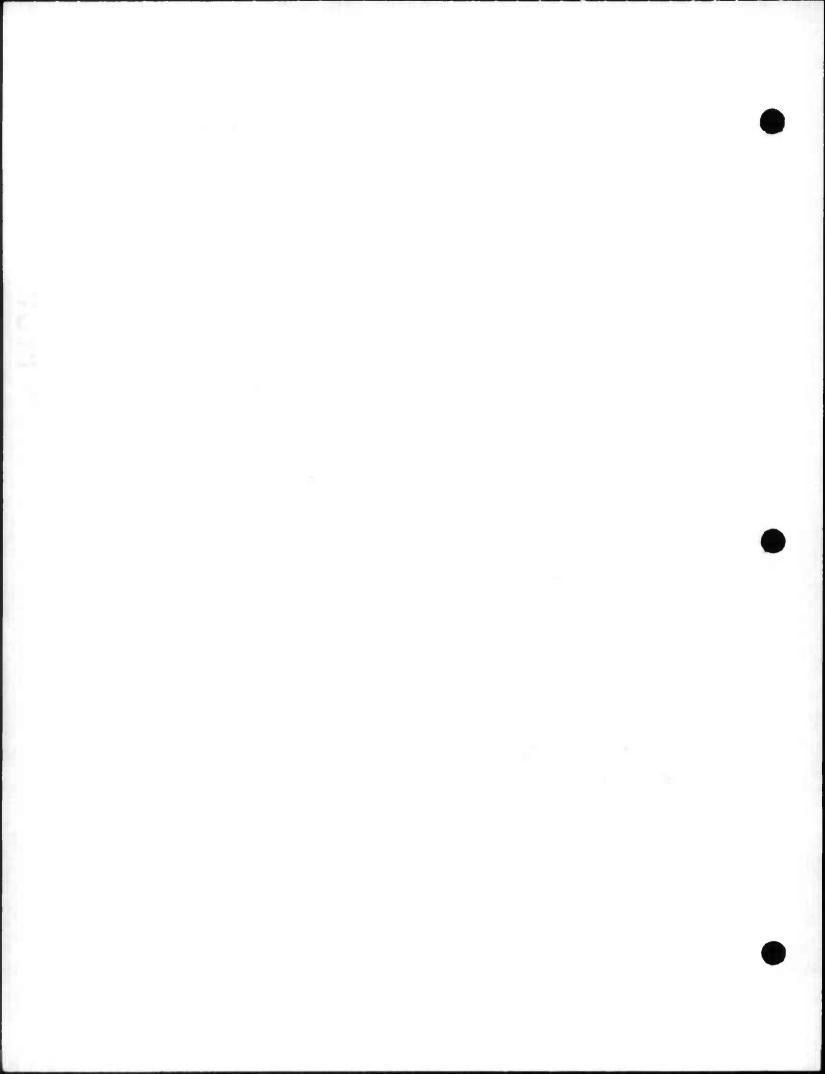
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atte	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use ;	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07794 95 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Dartene 27 fortune 1218 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) OCT 12 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 213-64-1028 1 - M 2 - F DAYS HOURS YRS. 40 MARYLAND 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND ANNE ARUNDEL ANNAPOLIS 1X YES 2 NO FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 27 HICKS AVENUE 21401 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. Il yes, specify Cuban, Mexican, Puerto Ri 1 YES 2 NO Specify: 1 Never Married 2 X Merried BY 3 Widowed 4 Divorced BLACK BE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify Elementary/Secondary (0-12) College (1-4 or 5+) ADMIMSTRATIVE ASSISTANT CORPORATE OFFICES 3yrs. A.A. MEDICAL CENTER 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIAM DYSON GENEVIEUE ADAMS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 27 HICKS AVENUE ANNAPOLIS MD 21401 LEWIS FORTUNE 20a. METHOD OF DISPOSITION
1 Survey Burlel 2 Cremation 3 Remote 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC Lavy 23. PART I. Enter the diseases, Dr shock, or heart fellure I IMMEDIATE CAUSE (Final disease or condition resulting in death) BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in deeth) LAST PART II. Other algnificant conditions **DID TOBACCO USE CONTR** 25. WAS CASE REFERRED TO MEDICAL NO 1 YES 2 27. MANNER OF DEATH Natural 2 Ampider 5 Pending Investigation 3 Sulcide COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER CERTIFYINO PHYSIC

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ist only one cause	on each line	D.					Interval Between	
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a tren death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 70 hours after death with the State harr of Heath and Mental Howing princip remarking or removal	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN					
1. DECEDENT'S NAME (First, Midd Sister Mary					2. DATE OF DEATH MONTH D	AY Y	3. TIME OF OEATH			
4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Feb. 28	3, 1995	9:45 A M BIRTHPLACE (State or Foreign			
214-54-5748	1 🗆 M 2 🕞 🗗	92 YRS.	IONTHS DAYS	HOURS MIN.	(Month, Day, Year) Dec. 23,1	1902	New Jersey			
90. FACILITY NAME (# not institution Villa St. M:			Emmits	on Location of oi	EATH	of DEATH				
RESIDENCE OF DECEDE	COUNTY	40. 000	TOWN OR LOCA	7101						
Maryland	Frederick		mitsbur			10d. INSIDE CITY LIMITS? 1X YES 2 NO				
10e. STREET AND NUMBER			10	f. ZIP CODE		OF WHAT COUNTRY?				
333 South Set		21727				U.S.	Α.			
11. MARITAL STATUS 1 X Never Merried 2 Merri 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 - NO	If yes, sp	CENDENT OF HISPAI Hecity Cuban, Mexica 5 2 MO Specif	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	RACE — American Indian, Black, White, etc. Specify: White				
15, DECEDEN	IT'S EDUCATION est grade completed)	16a. DECEDENT'S U	SUAL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDUS	TRY			
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	rk done during me retired.)	ost of working	Member	of rel	igious communi			
	College 1-4	Teacher			Daughte	ers of	Charity			
17. FATHER'S NAME (First, Middle,	Lest)			18. MOTHER'S NA	ME (First, Middle, Maiden	Sumeme)				
Thomas A. I				Mary	Emma Herdi	igen				
19e. INFORMANT'S NAME (Type/Pr	rint)	19b. MAILING A	DDRESS (Street	and Number or Rural	Route Number, City or Tow	vn, State, Zip Co	ide)			
Sister Camil					mitsburg,	MD 2	21727			
20a METHOD OF DISPOSITION 1 ZABuriel 2 Cremation 3 4 Donation 5 Other (Spec	☐ Removal from State	other place)					y or Town, State			
		Josep	22. NAME A	ND ADDRESS OF FA	House I	3mm T C 8	sburg, MD			
►/1 \:.00:	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
23. PART I. Enter the disease, Dr complications that coused the deeth. Do not enter the mode of dying, such as cerdiac pr respiratory arrest, Approximete										
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING		rene c	letil Var	The Fo	let les	ith.	interval Between Onset and Daath			
CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
Sev S/P	The Dene	ntia oscula	A A	s cause given in	Pert I. 24a. WAS APPERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 X NO			
25. WAS CASE REFERRED TO ME EXAMINER?	DICAL HOSPITAL: 1 Inputlent 2 ER/Out	noticet 2 DOA	OTHER:	LACE OF DEATH (CA) - 4 4	The state of the s			
27. MANNER OF DEATH 1 🔀 Netural 5 🔲 Pend	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. IN	JURY AT ORK? YES 2 NO	8 N Other (Specify) 28d. DE\$CRIBE HOW					
3 Suicide 8 Could	d not be building, etc. (Spe	f — At home, ferm, str city)			281. LOCATION (Street City or Town, State	end Number or	Rural Route Number,			
ana!	IG PHYSICIAN: To the best of my know						euse(e) end manner as stated.			
296. SIGNATURE AND TITLE OF	10	noll	um	29c. LICENSE NU		_	IGNED (Mohit), Day, Year)			
11n.11	ASON WHO COMPLETED CAUSE OF DI	Sath (ITEM 27) (Type, F	Aus.	Fmm	: 15 burs	ma	21727			
31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	NATURE	4	F 111 M	9	. er c	3/10/			
J// MAR	# 1999 Jun a	TURKER NAME								

was a region of the same

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

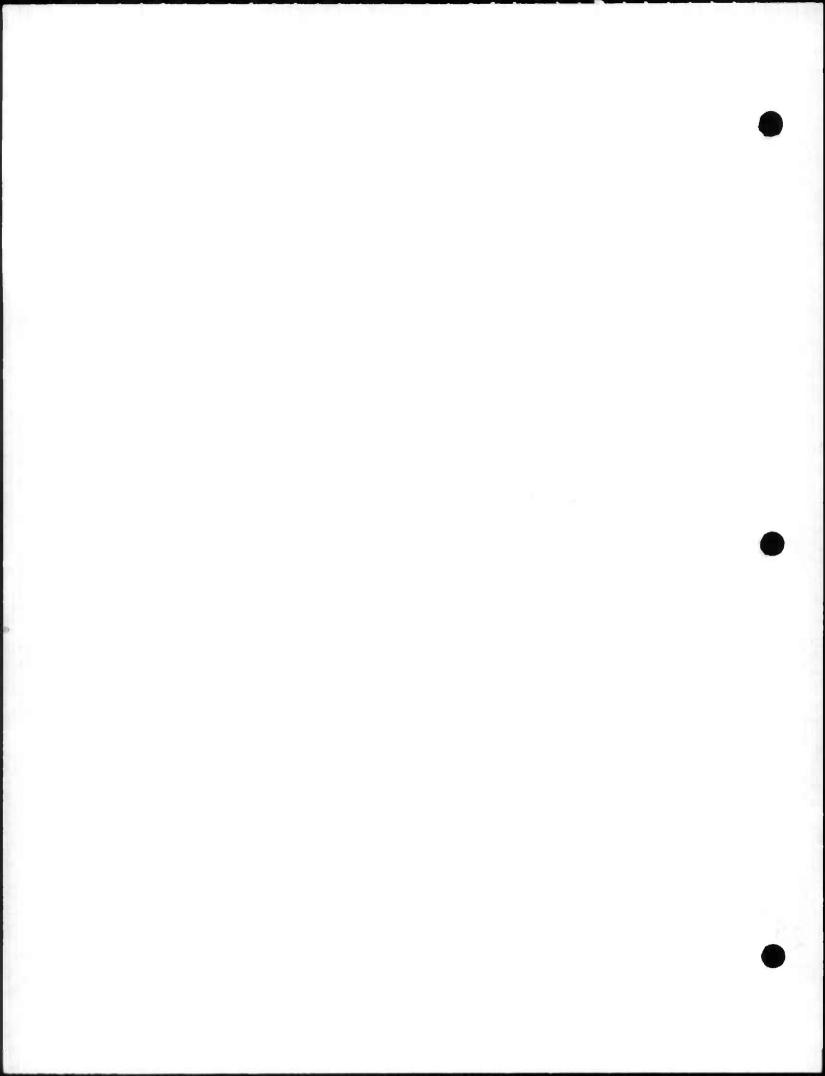
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIE CERTIFICATE OF DEATH REG. N	
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	1. DECEDENT'S NAME (First	, Middle, Last)					-			2. DATE OF	DEATH			3. TIME OF DEATH					
]	Lyman Ca	arlyle	Fich	or			3	Februa	757 9	¥ 1	Q YEAR	10:50 P M					
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.		IF UNDER	AWEAR	IF UNDER		7. DATE OF I		J, 1							
	379-18-341:		1 🕅 M 2 🗆 F	85	YRS.	MONTHS	DAYS	HOURS		(Month De	w Manet	000	Countr						
	9e. FACILITY NAME (If not in	-		03	1110.	at arry		OR LOCATIO		June 3	U, I			ndiana					
OC.	Charlestown								ON OF DE	ATH			NTY OF D						
DIRECTOR	RESIDENCE OF DEC		- CONTEST			Baltimore					Baltimore			more					
Ĭ	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION						10d. INSIDE CITY					
<u>ā</u>	Maryland	Anne	Arundel		S	evern	a P	ark						LIMITS?					
AL	10e. STREET AND NUMBER						101	. ZIP CODE	E			10g. CIT	ZEN OF W	HAT COUNTRY?					
띮	450 Benda	le Roa	d						2114	6			USA						
FUNERAL	11. MARITAL STATUS	V-1910	12. WAS DECEDEN	T EVER IN U.S.	RMED					IC ORIGIN? (S		or No-	14. RACE	- American Indian,					
BY	1 Never Married 2 1 3 Widowed 4 Divo		IF YES, GIVE V	YES 2 2	NO			ecify Cubii		, Puerto Ricar	ı, etc.)		Speci	White, etc.					
														White					
巴	(Specify only	EDENT'S EDUC y highest grade	ATION completed)	16a. [Give kind of view. Do NOT us	USUAL OC	CUPATIO	ON ast of workin	g	16b. KIN	D OF BUS	INESS/IND	USTRY						
٦	Elementary/Secondary (0	1-12)	College (1-4 or 5 +							77 6									
COMPLETED	17. FATHER'S NAME (First, M	iridia Lasti	JT	Me	chani	cal .	rng.					vern	ment						
		R. Fi	sher					18, MOTE		ME (First, Middle rgaret		,	30						
BE	190, INFORMANT'S NAME (7				ON HAH INO	ADDRESS	/Stance of	and Alternation		loute Number, C									
5	the same of the sa	Fisher								rna Pa									
				20h PLAC	EANDDATE		_		Deve			CATION -		- 0.1					
	20a METHOD OF DISPOSITE 1 N Burlet 2 Crematio 4 Donation 8 Other	n 3 🗆 Remo	val from State	Park	ematory or of	per placa)	าลไ	Park	2 /	28/95									
	21. SIGNATURE OF FUNERA		ENSEE	_ _ 0.2.10.						AUTY	NO	-KV II	ite,	TID .					
1	1. 1	10	10	1		Fr	anc	is J.	Co1	lins l	Fune	ral H	lome,	Inc.					
_	linot	ma	lam	bull		50	U U1	niver	sity	Blvd	.W.,S	Sil.S	pg.M	D 20901					
- 1	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between																		
	immediate cause (finel disease or condition Pneumonia									Onset and Daath									
	resulting in death)			_							5 days								
	DUE TO (OR AS A CONSEQUENCE OF): Dementia																		
CERTIFICATION	Sequentially list conditions,								Years										
Ä	cause. Enter UNDERLYING																		
표	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):									-									
E	resulting in death) LAST																		
	DART II Oaken de III	-A dial list			late to the														
MEDICAL	PART II. Other significa	nt conditions	contributing to	deeth but not	resulting I	n the unc	lerlying	g ceuse g	iven in i	Part I. 24a	PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO					
ă										10	YES 2	NO P		COMPLETION DF CAUSE DF DEATH?					
										_				1 YES 2 NO					
ż				LICE OF DE	ATH YF	SIN	IO 🗵	UNC	ERTAIN										
4			IBUTE TO CA																
S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	28. PL	CE OF DEAT	H (Check o							HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)						
IYSICIA	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	MEDICAL	HOSPITAL:	28. PL/	3 DOA	H (Check of OTHER 4 M Nursi	ng Hom		sidence (Other (Sp.	nclfy)								
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	MEDICAL	HOSPITAL:	28. PL/ ER/Outpatient INJURY	CE OF DEAT	OTHER 4 Nursi	ng Hom 28c. INJI WO	URY AT RK?		Other (Sp.		JURY OCC	CURED						
BY PHYSICIA	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident	MEDICAL	HOSPITAL: 1 Inpatient 2 28s. DATE OF (Month, Di	28. PL/ ER/Outpatient INJURY ny, Year)	GE OF DEAT	OTHER 4 Nursi E OF URY	ng Hom 28c. INJI WO 1 Y	URY AT RK? 'ES 2		28d. DESCRIE	BE HOW IN								
Ä	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 8 6	O MEDICAL Pending	HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, Date of D	28. PL/ ER/Outpatient INJURY	GE OF DEAT	OTHER 4 Nursi E OF URY	ng Hom 28c. INJI WO 1 Y	URY AT RK? 'ES 2			N (Street a			oute Number,					
Ä	25. WAS CASE REFERRED TO EXAMINER? 1	Pending investigation Could not be determined	HOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, Di 28a. PLACE Of building,	28. PLJ ER/Outpatient INJURY By, Year) F INJURY — At Pate. (Specify)	28b. TIME INJU	H (Check of OTHER 4 M Nursi	ng Hom 28c. INJI WO 1 Y	URY AT RK? 'ES 2] NO	281. LOCATION City or You	N (Street as	nd Number	or Rural R	oute Number,					
B	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 1 2 Accident 3 Suicide 8 0 4 Homicide 29s. CERTIFIER (Check only) 1 CERT	Pending prestigation Could not be determined	HOSPITAL: 1 Inpatient 2 28s. DATE OF (Month, D.) 28s. PLACE Of building,	28. PLJ ER/Outpatient INJURY sy, Year) F INJURY — At P stc. (Specify) my knowledge, c	DOA 28b. TIME INJUDICE OF DEAT	OTHER 4 Nursi E OF URY M treet, fecto	ng Hom 28c. INJ WO 1 V	URY AT RK? (ES 2 end place,	NO end due t	28d. DESCRIE 28f. LOCATIO City or Tot	N (Street a. wn, State)	nd Number	or Rural A						
B	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 8 0 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDIC	Pending investigation Could not be determined IFYING PHYSIC CAL EXAMINER	HOSPITAL: 1 Inpatient 2 28s. DATE OF (Month, D.) 28s. PLACE Of building,	28. PLJ ER/Outpatient INJURY sy, Year) F INJURY — At P stc. (Specify) my knowledge, c	DOA 28b. TIME INJUDICE OF DEAT	OTHER 4 Nursi E OF URY M treet, fecto	ng Hom 28c. INJ WO 1 V	URY AT RK? (ES 2 end place,	NO end due t	28d. DESCRIE 28f. LOCATIO City or Tot	N (Street a. wn, State)	nd Number	or Rural A	oute <i>Number,</i> end manner es stated.					
E COMPLETED BY	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 1 2 Accident 3 Suicide 8 0 4 Homicide 29s. CERTIFIER (Check only) 1 CERT	Pending investigation Could not be determined IFYING PHYSIC CAL EXAMINER	HOSPITAL: 1 Inpatient 2 28s. DATE OF (Month, D.) 28s. PLACE Of building,	28. PLJ ER/Outpatient INJURY sy, Year) F INJURY — At P stc. (Specify) my knowledge, c	DOA 28b. TIME INJUDICE OF DEAT	OTHER 4 Nursi E OF URY M treet, fecto	ng Hom 28c. INJ WO 1 V	URY AT RK? /ES 2 end place, meth occurr	end due to	281. LOCATION City or You to the cause(e) ime, dete and	N (Street a. wn, State)	nd Number	or Rural Rued. ed. e ceuse(e)	end manner es stated. (Month, Day, Year)					
BE COMPLETED BY	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 8 6 4 Homicide 8 6 298. CERTIFIER (Check only one) 2 MEDI	Pending investigation Could not be determined IFYING PHYSIC CAL EXAMINER	HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, Dr. 28e. PLACE Of building. IAN: To the best of : On the basic of e)	28. PLJ ER/Outpatient INJURY INJURY — At P etc. (Specify) my knowledge, c tamination and/o	CE OF DEAT 3 □ DOA □ 28b. TIMMI 1 Norme, ferm, a 1 Investigation	H (Check o	ng Hom 28c. INJ WO 1 V	URY AT RK? /ES 2 end place, meth occurr	end due t	281. LOCATION City or You to the cause(e) ime, dete and	N (Street a. wn, State)	nd Number	or Rural Rued. ed. e ceuse(e)	end manner es stated.					
E COMPLETED BY	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 8 0 4 Homicide 29s. CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	Pending Investigation Could not be determined IFYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	HOSPITAL: 1 Inpatient 2 28s. DATE OF (Month, D.) 28s. PLACE Of building, 1AN: To the best of : On the basic of e) COMPLETED CAUS	28. PLJ ER/Outpatient INJURY sy, 'ber' F INJURY — At P stc. (Specify) my knowledge, c tamination and/o	CE OF DEAT 3 DOA 28b. TIMMI Norme, ferm, s esth occurre investigation	H (Check o OTHER 4 M Nursi E OF URY M Itreet, fecto d at the tin n, in my op	ng Hom 28c. INJ WO 1 Ty, office	end place, seth occurr 29c. LICE	end due to dat the t	281. LOCATION City or Too to the cause(e) time, date and BER	N (Street a. wn, State)	nd Number	or Rural Ri ed. e ceuee(e) E SIGNED	end manner es stated. (Month, Day, Year) ry 27,1995					
BE COMPLETED BY	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 6 0 4 Homicide 298. CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF Sharon J. M.	Pending mreetigation Could not be determined IFYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	HOSPITAL: 1 Inpetient 2 28s. DATE OF (Month, D.) 28e. PLACE O building, IAN: To the best of : On the basic of e) COMPLETED CAUS. Ck, M.D.	28. PLJ ER/Outpatient INJURY INJURY INJURY At P stc. (Specify) Imp knowledge, camination and/o	CE OF DEAT 3 DOA 28b. TIMMI Norme, ferm, s esth occurre investigation	H (Check o OTHER 4 M Nursi E OF URY M Itreet, fecto d at the tin n, in my op	ng Hom 28c. INJ WO 1 Ty, office	end place, seth occurr 29c. LICE	end due to dat the t	281. LOCATION City or Too to the cause(e) time, date and BER	N (Street a. wn, State)	nd Number	or Rural Rued. ed. e ceuse(e)	end manner es stated. (Month, Day, Year) ry 27,1995					
BE COMPLETED BY	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 8 6 4 Homicide 8 6 298. CERTIFIER 1 X CERTIFICATION CONSTRUCTION	Pending investigation Could not be determined IFYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	HOSPITAL: 1 Inpatient 2 28e. DATE OF (Month, D. 28e. PLACE Of building. IAN: To the best of : On the basic of :) COMPLETED CAUS. Ck, M.D.	28. PLJ ER/Outpetient INJURY 19, 'ber' 1NJURY — At P stc. (Specify) my knowledge, of taminetion and/outpetient The off DEATH (IT 711 1	CE OF DEAT 3 DOA 28b. TIMM 28b. TIMM 10me, ferm, s 4 Investigation EM 27 (Type, Aaider	H (Check o OTHER 4 M Nursi E OF URY M Itreet, fecto d at the tin n, in my op	ng Hom 28c. INJ WO 1 Ty, office	end place, seth occurr 29c. LICE	end due to dat the t	281. LOCATION City or Too to the cause(e) time, date and BER	N (Street a. wn, State)	nd Number	or Rural Ri ed. e ceuee(e) E SIGNED	end manner es stated. (Month, Day, Year) ry 27,1995					
BE COMPLETED BY	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 8 6 4 Homicide 8 6 298. CERTIFIER 1 X CERTIFICATION CONSTRUCTION	Pending investigation Could not be determined IFYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	HOSPITAL: 1 Inpetient 2 28s. DATE OF (Month, D.) 28e. PLACE O building, IAN: To the best of : On the basic of e) COMPLETED CAUS. Ck, M.D.	28. PLJ ER/Outpetient INJURY 19, 'ber' 1NJURY — At P stc. (Specify) my knowledge, of taminetion and/outpetient The off DEATH (IT 711 1	CE OF DEAT 3 DOA 28b. TIMM 28b. TIMM 10me, ferm, s 4 Investigation EM 27 (Type, Aaider	H (Check o OTHER 4 M Nursi E OF URY M Itreet, fecto d at the tin n, in my op	ng Hom 28c. INJ WO 1 Ty, office	end place, seth occurr 29c. LICE	end due to dat the t	281. LOCATION City or Too to the cause(e) time, date and BER	N (Street a. wn, State)	nd Number	or Rural Ri ed. e ceuee(e) E SIGNED	end manner es stated. (Month, Day, Year) ry 27,1995					





BALTIMORE, MARYLAND 21215-0020	I hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAH			EKIIF	ICAIL	- OF	DEA	H	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF MONTH	DEATH	v	YEAR	3. TIME OF DEATN
	WALTER CLIFT	FORD_FISH	IER					+	ehru		.,		7:30 a ^M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF	BIRTH	7. U. s	S. BIRTI	PLACE (State or Foreign
	146-07-9055	1 🔀 M 2 🗆 F	80	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Di		14	N OT 7	m Jersey
	9a. FACILITY NAME (If not institution, give s	reet and number)			9b. CITY	TOWN C	R LOCATION	ON OF DEA		7 9 L J		INTY OF D	EATN
E C	5205 Paducah Road				Co.	1100	e Pa:	rk			Pr	ince	Georges
5	RESIDENCE OF DECEDENT					1108	C I a.				11.	Ince	Georges
DIRECTOR	10a. STATE 10b. COUNTY	•		10c. CIT	Y, TOWN O	R LOCAT	ION			-			10d. INSIDE CITY LIMITS?
□	Maryland Montg	omery		Si	lver	Spr	ing						1 YES 2 NO
AL	10e. STREET AND NUMBER					101	. ZIP CODE		***		10g. CIT	IZEN OF V	VNAT COUNTRY?
FUNERAL	311 Hillmoor Driv	e					2090	01				1	USA
5	11. MARITAL STATUS	12. WAS DECEDENT EV			13. 1	WAS DEC	ENDENT O	F NISPANI	C ORIGIN? (S	pecify Yes	or No-	14. RACE	— American Indian,
	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE WAR		10				n, Mexican, Specify:	Puarto Rica	n, etc.)			r, whita, atc.
ВУ	3 X Widowed 4 Divorced												,
	15. DECEDENT'S EDUC (Specify only highest grade		16a. DE	CEDENT'S	USUAL OC	CCUPATIO	ON st of workin	a	16b. Kil	D OF BUS	INESS/IN	DUSTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	e retired.)			•					
4		4	Ele	ctri	cal H	Engi	neer			Gov	ernm	ent	
COMPLETED	17. FATNER'S NAME (First, Middle, Lest)						18. MOTI	ER'S NAM	E (First, Midd	le, Malden	Sumame)		
BE	Frederick Harry	Charles Fi	sher					Anna	Wieb	er			
2	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS	(Street a	nd Number	or Rural Ro	oute Number, (City or Town	, State, Zip	o Code)	
-	Joyce E. Chambers		5	205	Paduo	cah	Road	Col1	ege P	ark,	MD :	20740)
	209, METHOD OF DISPOSITION 1 \(\text{\(\text{Merrico}\)} \) Burial 2 \(\text{\(\text{Cremation}\)} \) Rame	muni fanum Ctata	20b. PLACE			ITION (Na	me of		DATE	20c. LOC	CATION —	City or To	wn, Stete
	4 Donation 5 Other (Specify)	John Tront State	Fort I	inco	ln C	emet	erv	3/	1/95	Brei	itwoo	od.ma	ryland
	21. SIGNATURE OF FUNERAL SERVICE LIE	ENSEE			22.1	NAME AN	D ADDRES	S OF FACI	LITY				
	► YELLOW /\ (1)	140			Fr	canc	is J	Col	lins	Fune	ral I	Hm.,	Inc.
	23. PART I. Enter the diseases, or o	omplications that as	wood the de	ath Da a									MD 20901
	ahock, or heart failure.	List only one ceuse	on each line		iot enter	the mo	de oi dyi	ng, sucn	aa cerdiec	or raepli	ratory an	reat,	Approximate Interval Between
- 1	IMMEDIATE CAUSE (Finel disease or condition	8											Onast and Death
	resulting in death)		1 G			m							MONTH
		DUE TO (OR	AS A CONSEC	DUENCE OF	//								
S	Sequentially list conditions,	X))	/								
Ē	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH	AS A CONSEC	DUENCE OF	7;								
5	CAUSE (Disease or Injury	DUE TO (OR	AS A CONSEC	NIENOE OF									
Ē	that initiated events reaulting in deeth) LAST	. DOE TO (OR	AS A CONSEC	JUENCE OF	·}:								
英		1											
EDICAL CERTIFICATION	PART II. Other algnificant condition	contributing to dec	th but not r	aeulting i	n the un	derlying	cause g	Iven in P	art I. 24	. WAS AN		24b	WERE AUTOPSY FINDINGS
2										PERFOR	-		AVAILABLE PRIOR TO COMPLETION OF CAUSE
									_ ''	YES 2	410		OF DEATH?
Σ	DID TOBACCO USE CONTI	PIRLITE TO CALLS	E OE DEA	TH VE	с П »	IO F	LING	ERTAIN				-1	1 TYES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	IDDIE TO CAUS		E OF DEAT			UNC	EKIAIIY					
PHYSICIAN:	EXAMINET?	HOSPITAL:			OTHER	R:							
ž+	27. MANNER OF DEATH	1 Inpetient 2 ER		□ DOA				-	Other (Sp		1 01 1000 1 TO T	Olimes.	
	1 Netural 5 Pending	(Month, Day, Y			URY	28c. INJI	RK?		28d. DESCRE	BE NOW IN	JURY OC	CURED	
B₹	2 Accident Investigation	00- PU 405 05 W	######################################			1 🗌 Y							
	3 Suicide 8 Could not be determined	28a. PLACE OF IN- building, etc.	(Specify)	me, farm, s	treet, facto	ory, office	1	1	28f. LOCATIO City or To	N (Street a: wn, State)	nd Number	r or Rural F	loute Number,
E													
립	29a. CERTIFIER (Check only	CIAN: To the best of my	knowledge, de	ath occurre	d at the ti	me, deta	and placa,	and dua to	the cause(s) and man	ner as stat	ted.	
COMPLETED	one) 2 MEDICAL EXAMINE) and manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIE	10		4				NSE NUME		L			(Month, Day, Year)
8	Mugust)	Codien	wh	W			42	12	30	_ 1	6	11000	27 1002
2	30 JIAME/AND ADDRESS OF PERSON WHO	COMPLETED CALLE O	F DEATH STEE	8 27) (Tope	Printi		10.	10 (50	$\overline{\mathbb{A}}$	4/10	roug	01/1773
	Augusto P. Ra	duditos.	MUD	500	19 8	Der.	here	NO	C	me	2	us.	3117116
A	31. DATE FILED (Month, Day, Vasy)	32/ REGISTRAN'S	SIGNATURE	200	1	16	nen	1	7	1 m	1/	-	140
- 1	FFR 28 1995	Julia Atamil	or Parl	11	500	100			V	V			·* ·
		There we would	an a real of	All									

after death, Page 6 may be retained by the hosp y the funeral director, page 5 should be detache noval.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing A hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
0 5 -	

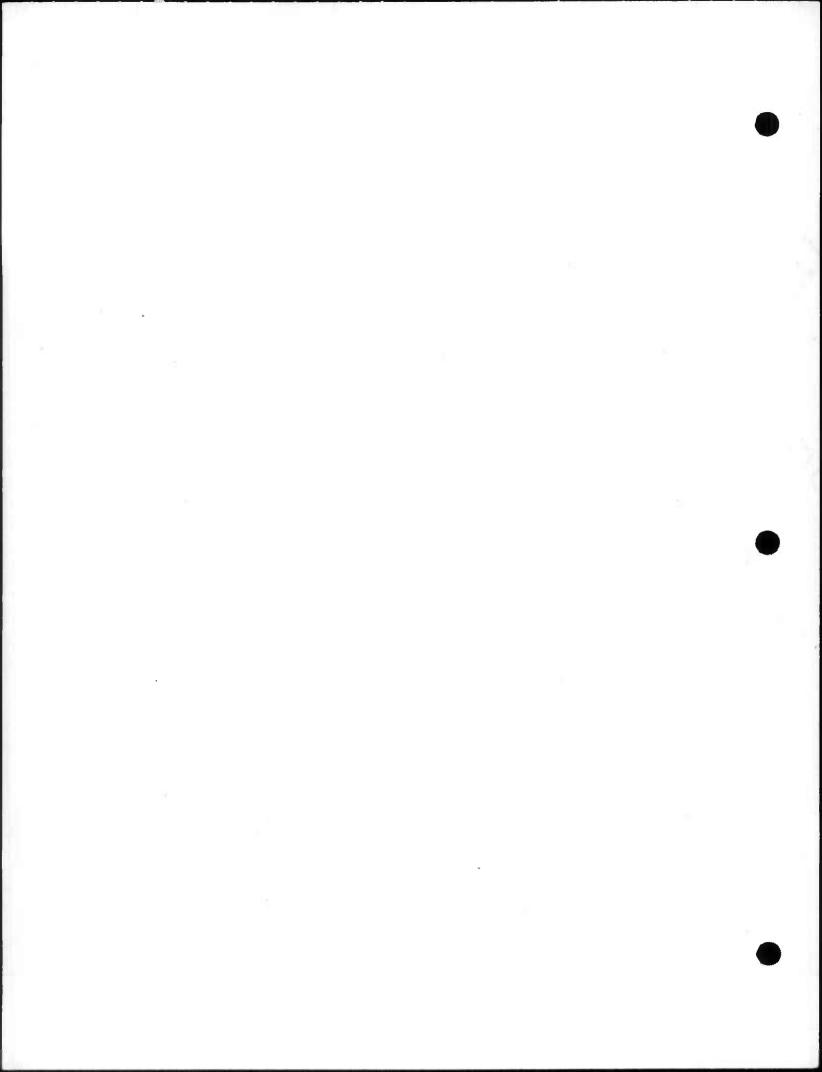
MGRON C. CA 31. DATE FILEO (Month, Day, Year) FFR 2.8 1995

	9 mended # 1 1 - STATE REGISTRAR	2/28/95- STATE OF MARYLAND	M R DEPARTM ERTIFICA	ENT OF H	Monta EALTH AND M DEATH	ENTAL HYGIEN	2	5 n 0 7 7 9 8
TO BE COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 5. 229-60-2221 9a. FACILITY NAME (if not institution, give stree Holy Cross Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Montg 10c. STREET AND NUMBER 7525 Carroll Avenu 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCAT (Specify only highest grade cor	Omery e 2. WAS DECEDENT EVER IN U.S. & FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES ION 16a. Di () () () () () () () () () () () () ()	YRS. MONT 9b. S 10c. CITY, TO' T T T T T T T T T T T T T	CITY, TOWN OF CI	B LOCATION OF DEA Spring ON Park ZIP CODE 200 NDENT OF HISPANIC OIT OF Working To working The Mother's NAMI Callie of Number or Rural Ro Tive Lees The OIT OF ADDRESS OF FACIL OF ADD	7. DATE OF BIRTN (Month, Day, Year) August 23 TN 212 C ORIGIN? (Specify Veryuario Rican, etc.) 16b. KIND OF BU Federa: E (First, Middle, Meiden Hugh Gill ute Number, City or Res Sburg, Flor DATE 20c. LO 3/95 Suit	896 8 896 N 9c. COUNT MO 10g. CITIZE 10g. CITIZE SINESS/INDUS 1 GOVE Surmane) Dert m, State, Zip corrida Deation — Chetland, I	rnment 34788 y or Town, State Maryland me, Inc.
CERTIFICATION	23. PART I. Enter the diseases, pr conshock, or heart feliure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):	100 Uninter the mod	e of dying, auch	Blvd., W.	Sil.S	pr., MD 20901 Approximeta interval Between Onset and Death
PHYSICIAN: MEDICAL	1 YES 2 TO 11 27. MANNER OF DEATN 1 Netural 5 Pending	BUTE TO CAUSE OF DEA	ATH YES [NO Preck only one) HER: Nursing Nome 28c. INJU	UNCERTAIN 5 Rasidence 8	PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
TO BE COMPLETED BY	3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER	28a. PLACE OF INJURY — At he building, etc. (Specify) N: To the best of my knowledge, de on the best of avamination and/or	nath occurred at t	the time, date a	nd place, and due to	ne, data and placa, an	nner as atated.	

ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 239 SHORTEN NOT

32. REGISTRAR'S SIGNATURE

95 Julia Shurdhoo Part II



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 🛫 hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hural-transit narmit. Pages 1 2 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after deal	IMPORTANT: If Item 28 is m	

							9	5 07799		
	REGISTRAR	TATE OF MARYLAND	/ DEPAR	TMENT OF CATE OF	HEALTH AND	MENTAL HYGIEN				
		ter		genb		tebruar	25/	3. TIME OF DEATH 0337 A M		
 	459-07-2354 15	₹ M 2 □ F 83	-	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) APRIL 2,	8. BIRTHPLACE (State or Fo Country) MISSOURI			
OR	9a. FACILITY NAME (If not institution, give street a SHADY GROVE ADVENTI				OR LOCATION OF D		9c. COUNTY OF DEATH MONTGOMERY			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCA	TION			10d. INSIDE CITY		
	MARYLAND MONTGO	DMERY	RC	CKVILLI	f. ZIP CODE			1 XYES 2 NO		
FUNERAL	11918 RENWOOD LANE				20852			ED STATES		
BY		ARMED NO	If yes, s	CENDENT OF NISPA becity Cuben, Maxico 5 2 NO Specif	NIC ORIGIN? (Specify Yearn, Puarto Rican, atc.) fy:	or No-	14. RACE — American Indian, Black, White, etc. Specify: WHITE			
TED	15. DECEDENT'S EDUCATION (Specify only highest grade complete)	eleted)		USUAL OCCUPATI ork done during m		16b. KIND OF BUS	SINESS/INDU			
COMPLETED	Elementary/Secondary (0-12) Col	11ege (1-4 or 5+) 5	ATTOR			FEDER	AL GO	VERNMENT		
	17. FATHER'S NAME (First, Middle, Last) GERSON FEIGENBA	AUM			10. MOTHER'S NA	AME (First, Middle, Meiden GLAASER		4		
TO BE	199. INFORMANT'S NAME (NyperPrint) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANETTE ROTHSCHILD (DAUGHTER) 2 ALMADEN PLACE, GAITHERSBURG, MD 20878									
	JEANETTE ROTHSCHILL 20g. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 X Removal fr			FDISPOSITION (N				18/8 Sty or Town, State		
	1 ABuriel 2 Cremetion 3 A Removal fr 4 Donation 5 Other (Specify)	WASE	ILNGTON	HEBREV	CONG.	2/26 WAS		ron, DC		
	A STANLE OF THE SERVICE CICENSE	7 -		DANZA		DBERG MEMO		CHAPELS, INC.		
	23. PART I. Enter the diseases, or complete the complete or heart failure. List of	iications that caused the	death. Do no	ot enter the mo	ROCKVILL ods of dying, suc	h as cardiac or respi	CKVIL ratory arre			
	shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Fine) disease or condition Concept in Heart For (1) and Concept in Heart For (1) and									
	disease or condition - a. Congestive Heart Failure One year Due to or as a consequence of: Coronary Artery Disease Years									
NO	DIE TO OD AS A CONSCIUENCE OF									
ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury									
ERTI	that initiated events resulting in death) LAST		SEGOLINOE OF)							
PHYSICIAN: MEDICAL CI	PART II. Other algnificent conditions con Diabetes	ellitus Type	et resulting in	the underlyin	g cause given in	Part i. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
I. ME	DID TOBACCO USE CONTRIBU	TE TO CAUSE OF DI	ATH YES	RON II	UNCERTAIN	<u></u>		1 TYES 3 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PL SPITAL:	ACE OF DEATH	(Check only one)	ORCERIAN					
HYS		Inpetient 2 ER/Outpetient 28s. DATE OF INJURY	3 DOA 28b. TIME	OF 28c, IN.	URY AT	8 Other (Specify) 28d. DESCRIBE NOW IF	NURY OCCU	PRED		
BY F	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	ULNI	M 1 🗆	PRK? YES 2 NO					
TED	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJURY — At building, etc. (Specify)	nome, mrm, sq	reet, factory, offic		28f. LOCATION (Street a City or Town, State)	nd Number o	r Rural Route Number,		
COMPLETED		To the best of my knowledge,								
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	Same of exemination and/o	or investigation.	, in my opinion, o	29c. LICENSE NUM		29d. DATE	cause(a) and menner as stated. SIGNED (Month, Day, Year)		
10 B	100/10	Puller of DEATH OF	111		D399	34	Fel	or vary 25, 1995		

Raporus NO

LETED CAUSE OF DEATH (ITEM 27) (Type, Print)

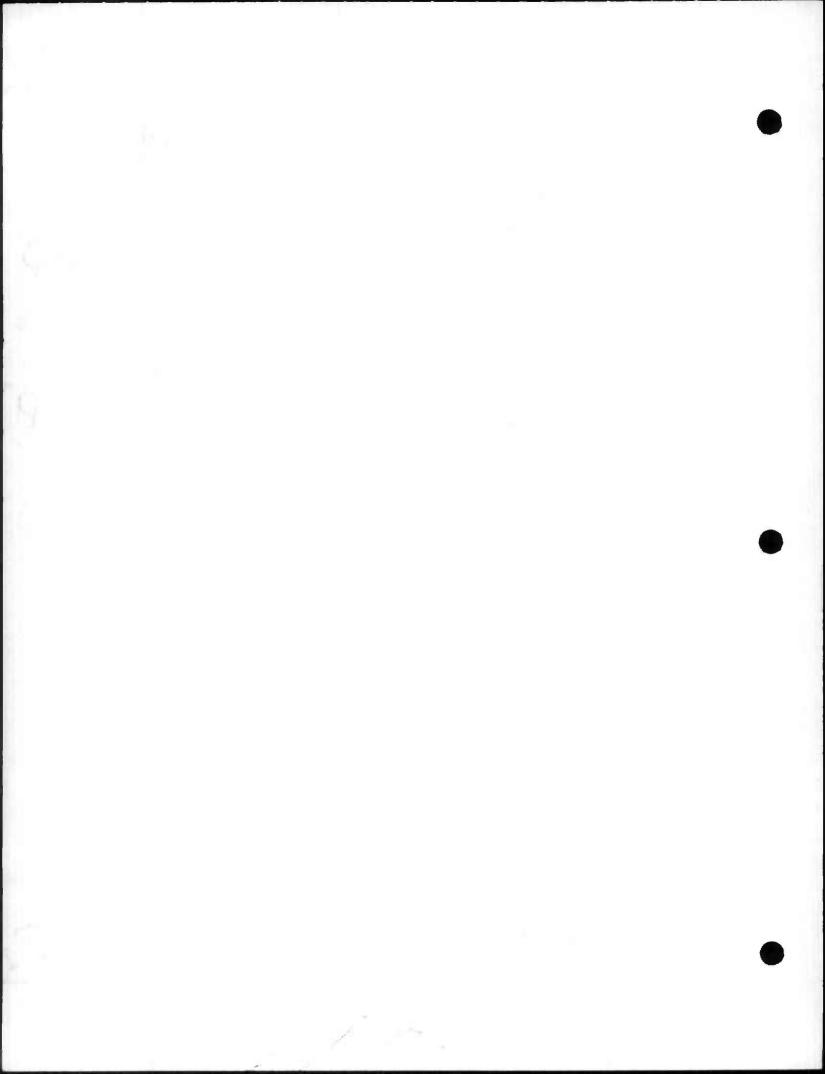
HUNGERFORD

2 MD 250 Hew. 3. REGISTRAR'S SIGNATURE Fals Studion Randall

STEVEN T. COUL.

31. DATE FILED (Month, Day, Year)

FEB 27 1995

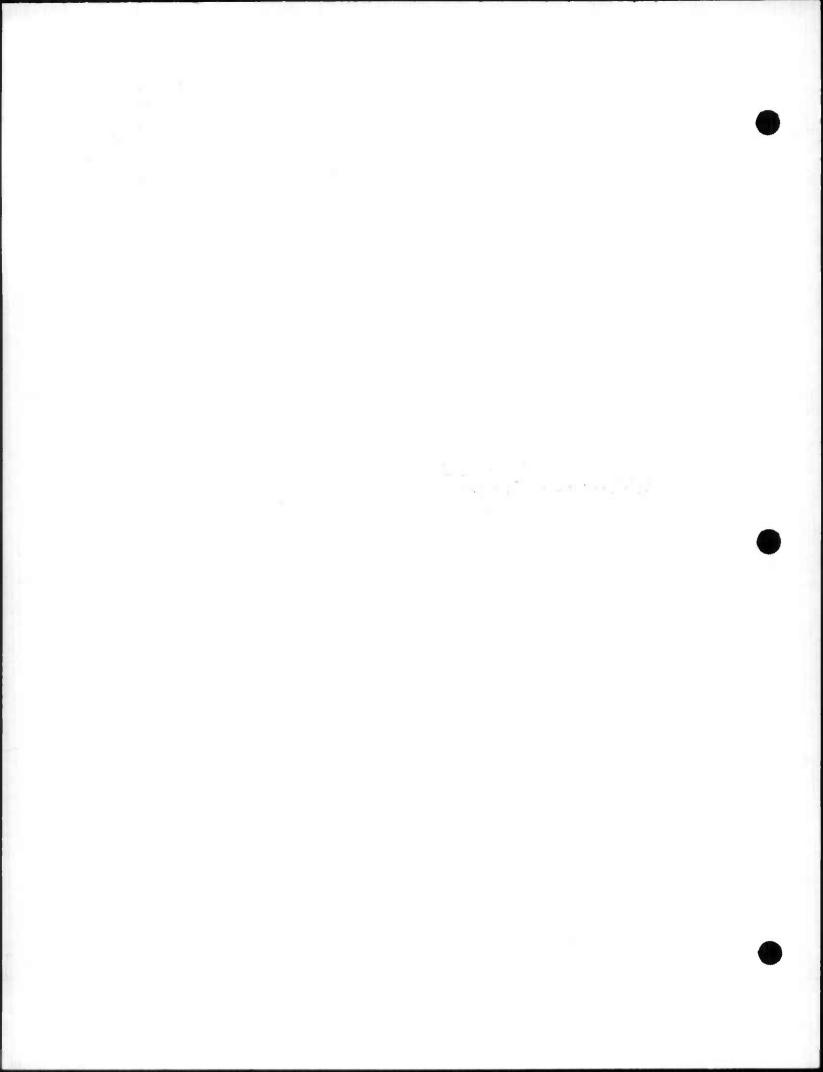


hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769 TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

	The state of the s											
4 I	1. DECEDENT'S NAME (First,								2. DATE OF DEATH	MY	YEAR	3. TIME OF DEATH
		Clarer				W, Jr.				28, 1		4:55 A
	4. SOCIAL SECURITY NUMBER	JER	5. SEX		rs. lest birthday)	IF UNDER 1 YE		1 24 HRS.	7. DATE OF BIRTH			PLACE (State or Foreig
	213-16-9778		1 📉 M 2 🗆 F	74	YRS.	MONTHS DA	WS HOURS	MIN.	Aug. 6, 192			ryland
	9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH		
O.	Memorial Ho	spital				Cumberland				Allegany		
5	RESIDENCE OF DEC	CEDENT								Allegany		
DIRECTOR	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN OR L	OCATION		10d. INSIDE CITY LIMITS?			
	Maryland	Alleg	any			umberl	and				1 YES 2 X NO	
\A	10e, STREET AND NUMBER						10f. ZIP CODE	E		10g. CITIZ	EN OF W	HAT COUNTRY?
띮	11726 Bed	ford R	D, NE				2150	2	USA			
FUNER	11. MARITAL STATUS		12. WAS DECEDEN		ER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGI						14. RACE	- American Indian,
ВУ	1 Never Merried 2 X 3 Widowed 4 Divo		FORCES? 1 IF YES, GIVE W			NO If yee, specify Cuben, Maxican, Puerto Rican, etc.)						White, etc.
		- 1		WW I	I			_				WIII CC
TO BE COMPLETED	15. DEC (Specify only	EDENT'S EDUC	CATION completed)	16.	a. DECEDENT'S		PATION g most of workin	na	16b. KIND OF BU	SINESS/IND	USTRY	
	Elementary/Secondary (0	⊢12)	College (1-4 or 5+		life. Do NOT us	se retired.)	y most or worth	.9				
	8				Machin	ist			Rail Ro	ad		
	17. FATHER'S NAME (First, M						18. MOTH	HER'S NAM	E (First, Middle, Maiden	Surname)		
	Elmer Clare	Elmer Clarence Furlow, Sr.					Tin	ie L.	(O'Baker)		
	190. INFORMANT'S NAME (7)				19b. MAILING	ADDRESS (St			oute Number, City or Tox		Code)	
	Cornelia B.	Furlo	N		11726	Bedfo	rd RD.	Cumb	erland, M	D 21	502	
	204 METHOD OF DISPOSITI	ION		20b.PL	ACE AND DATE	OF DISPOSITIO	N /Neme of			CATION —		rn. State
	1 XBuriel 2 Cremetio 4 Donetion 5 Other	in 3 ☐ Remo (Specify)	oval from State	ROC	ky Gap	ther place)	Cem	3/2	1.	ntsto		
	21. SIGNATURE OF FUNEBAL	L SERVICE LIC	ENSIE ,	1		22. NAN	E AND ADDRES	SS OF FACI	UTY Kight E	hnoro	lie,	MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Kight Funeral Home 309-311 Decatur St., Cumberland, MD 215									me		
	23. PART i. Enter the di	wire	- , - ,	701								MD 2150.
	immediate cause (Final disease or condition resulting in death) Due to (or as a consequence of): Coronary frey disease Unishmediate Consequence of the coronary frey disease											
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											unkno	
BITTE	that initiated events		DUE TO	OR AS A CO								
뜅	that initiated events resulting in death) LAS	T	l									
뜅	that initiated events resulting in death) LAST	T d	contributing to				lying cause g	given in P	art f. 24s. WAS AN			AVAILABLE PRIOR TO
뜅	that initiated events resulting in death) LAS	T d	contributing to				lying cause g	given in P	art I. 24s. WAS AN PERFOI	RMED?		AVAILABLE PRIOR TO
MEDICAL CE	PART II. Other significe	ont conditione	contributing to	death but r	not resulting	in the ∪nder	O1 = 03		PERFOI	RMED?		AVAILABLE PRIOR TO COMPLETION DF CAU
MEDICAL CE	PART II. Other significe	ont conditions	contributing to	death but r	DEATH YE	in the under	☐ UNC		PERFOI	RMED?		AVAILABLE PRIOR TO COMPLETION DF CAU OF DEATH?
MEDICAL CE	PART II. Other significe	ont conditions	e contributing to	death but r	not resulting	in the under	☐ UNC		PERFOI	RMED?		AVAILABLE PRIOR TO COMPLETION DF CAU OF DEATH?
MEDICAL CE	PART II. Other significed DID TOBACCO USES. WAS CASE REFERRED TO	ont conditions	contributing to	USE OF E	DEATH YE	in the Under	UNC	ERTAIN	PERFOI	RMED?		AVAILABLE PRIOR TO COMPLETION DF CAUS OF DEATH?
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BY PHYSICIAN: MEDICAL CE	That initiated events resulting in death) LAST resulting in death) LAST PART II. Other significes of the control of the contro	SE CONTR O MEDICAL Pending Investigation Could not ba determined	RIBUTE TO CAI HOSPITAL: Description Description	USE OF E 26. I ER/Outpatter injury y, 'bear' injury — finjury —	DEATH YE PLACE OF DEAT At home, ferm, a	in the under S NO IN (Check only OTHER: 4 Nursing E DF URY M 1 streel, factory,	UNC One) Home 5 Rai INJURY AT WORK? YES 2 office date and place, on, death occurre	ERTAIN saldence 8 No note to the saldence at the saldence to t	Other (Specify) 286. LOCATION (Street City or Town, State) the cause(s) and meme, data and place, and	NJURY OCC	URED Or Rural Ro	AMALABLE PRIOR TO COMPLETION DF CAUNOF DEATH! 1 YES 2 NO
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BE COMPLETED BY PHYSICIAN: MEDICAL CE	That initiated events resulting in death) LAST resulting in death) LAST PART II. Other significe DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 1 3 Suicide 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SE CONTR D MEDICAL Pending Investigation Could not ba determined IFYING PHYSIC CAL EXAMINER OF CERTIFIER	EIBUTE TO CAL HOSPITAL: 1 DR Inpetient 2 28e. DATE OF (Month, Da 28e. PLACE OF building, a	USE OF E 26. I ER/Outpatien INJURY y, Year) F INJURY — j alic. (Specify) my knowledge aminetion and	DEATH YE PLACE OF DEAT 1 DOA 28b, TIM INJ At home, farm, a	in the Under S NO IN (Check only OTHER: 4 Nursing E DF URY M 1 streel, factory, and at the time, n, in my opinion	UNC one) Home 5 Ra: INJURY AT WORK? YES 2 offlice date and place, on, death occurrence, 29c. LICE	ERTAIN saldence 8 No note to the saldence at the saldence to t	Other (Specify) 28d. LOCATION (Street City or Town, State) the cause(s) and merme, data and place, are	NJURY OCC	URED or Rural Ro d. cause(a) SIGNED (:	COMPLETION DF CAUSOF DEATH? 1 YES 2 NO
E COMPLETED BY PHYSICIAN: MEDICAL CE	That initiated events resulting in death) LAST resulting in death) LAST PART II. Other significes of the part of t	T dent conditions SE CONTR O MEDICAL Pending Investigation Could not be determined IFYING PHYSIC CAL EXAMINER OF CERTIFIER	RIBUTE TO CAI HOSPITAL: 1 Pil Inpatient 2 28e. PLACE OF building, a CIAN: To the basis of axis.	USE OF E 26. I ER/Outpetter INJURY — / FINJURY — / FINJURY — / FINJURY — / FOR THE METERS AND THE METERS	DEATH YE PLACE OF DEAT 28b, TIM INJ At home, farm, a	in the under S NO N (Check only OTHER: 4 Nursing E DF 28c URY 1 Intreel, factory, and at the time, n, in my opinion Print)	UNC one) Home 5 Ra: INJURY AT WORK? YES 2 office date and place, on, death occurs 29c. LICE	ERTAIN Insidence 8 Insidence	Other (Specify) 28d. LOCATION (Street City or Town, State) the cause(s) and merme, data and place, and ser	NJURY OCC	URED or Rural Ro d. cause(a) SIGNED (:	AMALABLE PRIOR TO COMPLETION DF CAU- OF DEATH? 1 YES 2 NO unter Number, and manner as state Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL CE	That initiated events resulting in death) LAST resulting in death) LAST PART II. Other significe DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 1 3 Suicide 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SE CONTR O MEDICAL Pending Investigation Could not be determined OF CERTIFIER OF CERTIFIER F PERSON WHO Ca, Mem	RIBUTE TO CAI HOSPITAL: 1 Pil Inpatient 2 28e. PLACE OF building, a CIAN: To the basis of axis.	USE OF E 26.1 ER/Outpetler INJURY — / ilc. (Specify) my knowledge aminetion and E OF DEATH Spita	DEATH YE PLACE OF DEAT 28b, TIM INJ At home, farm, a e, death occurre d/or investigation (ITEM 27) (Type, 1 Medic	in the under S NO N (Check only OTHER: 4 Nursing E DF 28c URY 1 Intreel, factory, and at the time, n, in my opinion Print)	UNC one) Home 5 Ra: INJURY AT WORK? YES 2 office date and place, on, death occurs 29c. LICE	ERTAIN Insidence 8 Insidence	Other (Specify) 28d. LOCATION (Street City or Town, State) the cause(s) and merme, data and place, and ser	NJURY OCC	URED or Rural Ro d. cause(a) Signed (AMALABLE PRIOR TO COMPLETION DF CAU- OF DEATH? 1 YES 2 NO unter Number, and manner as state Month, Day, Year)



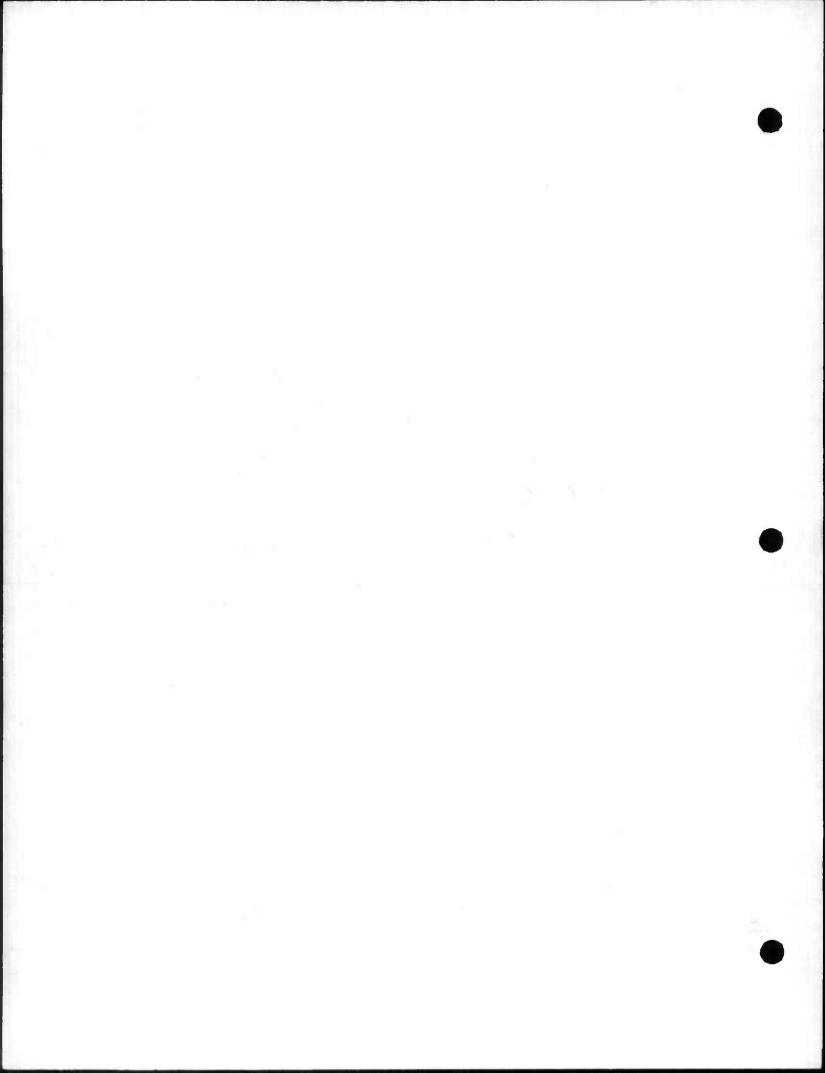
ay be retained by the hospital or attending physician.

page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should E, MARYLAND 21215-0020

DIVISION OF VITAL BECODE

BALIIMORE, MARYLAND	ours after death. Page 6 may be retained by the hosp	i in by the funeral director, page 5 should be detache or removal.	nedical examiner must be notified at once.	
DIVISION OF VIEW RECORDS, P.O. BOX 68/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF I	EALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)				DEM.	2. DATE OF DEATN		3. TIME OF DEATN	
		PHINE		FRYE		FEBRUARY 2	25, 1995	12:00 Pm	
	234 38 7709	☐ M 2 [XF	(In yrs. lest birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) MAY 5, 19	0. BIR	TNPLACE (State or Foreign of St. Virginia	
TOR	96. FACILITY NAME (If not institution, give stree SACRED HEART HOSP RESIDENCE OF DECEDENT				BERLAND	EATN	9c. COUNTY OF		
DIRECTOR	10e. STATE 10b. COUNTY	shire		rown on Local				10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
FUNERAL	P. O. Box 217		<u> </u>	10	26763			WHAT COUNTRY?	
В	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 XINO	If yes, sp	ENDENT OF NISPA ecity Cuban, Maxic 2 XNO Speci	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) fy:	Bie	CE — American Indien, ick, White, atc.	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementery/Secondary (0-12) N/A	TION mpleted) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT us	ork done durina ma	st of working	16b, KIND OF BUS	SINESS/INDUSTRY		
	17. FATHER'S NAME (First, Middle, Lest) HOW	ard Gulic	k		18. MOTNER'S NA Grac	AME (First, Middle, Meiden ee Blackbu	Sumema)		
TO BE	190. INFORMANT'S NAME (Type/Print) Jewell Mueller		P. O.	ADDRESS (Street a	nd Number or Rural 7, Sprin	Route Number, City or Town	n, State, Zip Code) 26763		
	20e. METNOD OF DISPOSITION 1 TO Burlel 2 Cremetion 3 Removal 4 Donation 6 Other (Specify)	from State can	o. PLACE AND DATE On the control of	en Cemet	ery Feb.	28,1995 G	cation — city or reenspri	· ·	
	21. SIGNATURE OF PUNERAL SERVICE LICENS	Me		Sha 230	ffer Fun East Ma	eral Home, in Street.	Romney	, WV 26757	
	23. PART I. Enter the diseases, or com ahock, or heert failure. List	t privious that cause t privione cause on e	d the deeth. Do n	ot enter the mo	de of dying, suc	ch aa cardiac or reapi	ratory arrest,	Approximata interval Between	
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE TO (OR AS A CONSCOUENCE OF):							
NO	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): 4 Week Due TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
	resulting in death) LAST	Cach	lkia					4-6 mos.	
DICAL	PART II. Other aignificant conditions c	ontributing to deeth b	ut not resulting in	the underlying	ceuse given in	Part i. 24a, WAS AN PERFOR	MED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
Z: ME	DID TOBACCO USE CONTRIB	UTE TO CAUSE C	F DEATH YES	S I NO R	UNCERTAI			1 YES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEATI						
HYS	1 YES 2 XNO 1	Inpatient 2 ER/Outs	atient 3 DOA 28b. TIME			6 Other (Specify) 28d. DESCRIBE NOW IN	I II III OCCUPED		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	IRY WO	RK? 'ES 2 NO	Zed. DESCRIBE NOW IP	SONT OCCURED		
	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, ferm, at	reet, fectory, office		281. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN 2 MEDICAL EXAMINER: O	N: To the best of my know On the basis of examination	ledge, death occurred n end/or investigation	f at the time, date , in my opinion, d	and piece, end due	to the ceuse(e) and man- tima, date end place, end	ner ea atated. I due to the cause	(e) and manner se stated.	
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	0.0	0		29c. LICENSE NUI	MBER	29d. DATE SIGNE	D (Month, Day, Ybar)	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DA	V and	Print)	0-17	526	FEBRU	ARY 27-95	
	DR. JOHN MEHANNA,				UMBERLAN	ND, MD 2150	2		
	31. DATE FILED (MORTH, Day, Year) MAR 0 1 1995	3. REGISTRAR'S SIGN					· · · · · · · · · · · · · · · · · · ·		



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the nospital or authoring programme.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that he death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Sizar and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

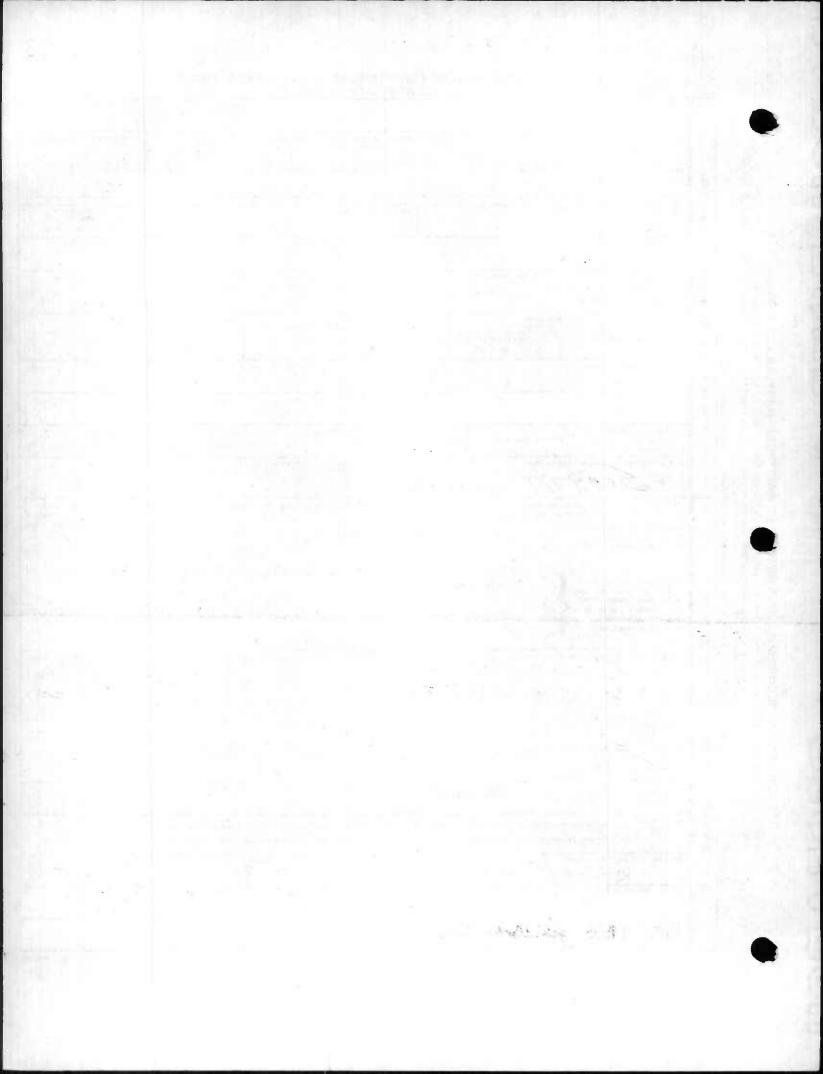
~ -

STATE	0F	MARYLAND	1	DEPARTMENT	0F	HÈALTH	AND	MENTAL	HYG	IENE
			F	RTIFICATE	0	F DEAT	TH		DEC	NO

1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIENI REG. NO.	E			
1. DECEDENT'S NAME (First, Middle Las	" ALVIN_ Fran		utrell	The attraction					
ALVIN F.	FUTREL	der err		03 02		8:05 a ^M			
4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cour	INPLACE (State or Foreign ntry)		
393-16-5454 9e. FACILITY NAME (If not institution, giv	1 XM 2 F	73 YRS.		R LOCATION OF DE	12/19/1921		sconsin		
Meridian Nursing			LaPlata		ATH	9c. COUNTY OF			
RESIDENCE OF DECEDENT						Charle	S		
10e. STATE 10b. COU			Y, TOWN OR LOCAT	ON			10d. INSIDE CITY LIMITS?		
Virginia 100. STREET AND NUMBER	None	Alex	andria	ZIP CODE			1 YES 2 NO		
205 Yoakum Pkwy	R1d 2 Apr 120	15	101.	2230	/.	USA	WHAT COUNTRY?		
11. MARITAL STATUS	12. WAS DECEDENT EVER	N U.S. ARMED	13. WAS DEC		IC ORIGIN? (Specify Yes		CE — American Indian,		
1 Never Married 2 Nerried	FORCES? 1 YES		If yes, spe		n, Puerto Rican, atc.)	Bia	ck, White, atc.		
3 Widowed 4 Divorced	Korea						White		
15. DECEDENT'S E (Specify only highest gro	ide completed)		VOIK done during mos		166. KIND OF BUS	INESS/INDUSTRY			
Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Test P			U.S.Go	37 T de			
17. FATHER'S NAME (First, Middle, Last)		1030 1	1100	16. MOTNER'S NAI	ME (First, Middle, Maiden				
Mart NMN Futrell				Audrey	NMN Lyons				
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e		loute Number, City or Town				
Misako NMN Futre	:11	205 Yo	akum Pkw	y Bld 2	#1205 Alex	andria,	VA 22304		
20a. METHOD OF DISPOSITION 1X Buriel 2 Cremation 3 Re	emoval from State	b. PLACE AND DATE of	OF DISPOSITION (Na			CATION — City or			
4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	A	rlington	Nationa	1 3	/8/95 Arli	ngton, V	A		
DA+N	2 A A				UNERAL HOM	E			
Folst "	Colla		P.O.	Box 65 A	lexandria,	VA 223	13		
23. PART I. Enter the diseases, part is shock, or heert fellur immediate CAUSE (Final disease or condition resulting in death)	a. SE	PS)S	ŋ:				Approximate interval Between Onset and Deeth		
Sequentially list conditions, if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF	ງ :	4 1	NFECTI	ON	48 HR		
PART II. Other significent conditions of the significent conditions of the significent conditions of the significant condition	one contributing to death in the D	1011 0	n the underlying	ceuse given in	Pert I. 24s. WAS AN PERFOR	MEO?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Che	ck only one)				
1 TES 2 NO	1 Inpatient 2 ER/Out	patient 3 🗆 DOA	OTHER: Nursing Nome	6 - Residence	6 Other (Specify)				
27. MANNER OF GEATN Netural 5 Pending	(Month, Day, Yeer)	26b. TIMI INJ	URY WO	RK?	28d. DEŞCRIBE HOW IN	JURY OCCURED			
2 Accident Investigation	260. PLACE OF INJURY	/_ At home form a		ES 2 NO	***************************************				
3 Suicide 6 Could not a	building, etc. (Spe	cify)	River, factory, office		26f. LOCATION (Street a. City or Town, State)	nd Number of Hura	Houte Number,		
	'SICIAN: To the best of my know NER: On the besie of exemination						(e) end menner ee stated.		
299. SIGNATURE AND TITLE OF CERTIF	1/10 en	W.	-M)	D - 44	1436	29d. DATE SIGNE	D (Morth, Day, Year)		
ASHVIN J	PATEL 6	03 Pos	Print) TOFFI	ERD	207 WAL	DORF.	MD 20602		
31. DATE FILED (Month, Day, Year) MAR 15 1995	22, REDISTRAR'S SIG	artell							

MAR 15 1995 July Marine Rody

19	1. DECEDENT'S NAME (Firs Middle U)	FRANE	Cl	-NIII		יר טו	EATH	2. DATE	REG. NO.		1 2	TIME OF DEATH	
	Anna	Colevein	5					MONT		7	YEAR	124 1	
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. las	t birthday)	IF UNDER 1 Y		UNDER 24 HRS.		OF BIRTN		BIRTNPL Country)	ACE (State or Foreign	
	214-09-1568	t 🗆 M 2 🏋 F	89	YRS.	MONTHS D.	WB HO	HURS MIN.	Jul		1905		land	
æ	9a. FACILITY NAME (If not institution, gh				9b. CITY, TO		OCATION OF DI			9c. COUNT			
5	Colton Villa Nursing Home Hagerstown Washington												
DIRECTOR	Moreon 7 cms d			t0c. CIT	Y, TOWN OR L						10	d. INSIDE CITY LIMITS?	
	Maryland 104. STREET AND NUMBER	Washingto	rı		над	erst						YES 2 NO	
FUNERAL	403 Garlinger A	venue				10f. ZIP	21740				USA	T COUNTRY?	
S	ti. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	IMED	13. WAS	DECEND	ENT OF HISPAI	NIC ORIGI	N? (Specify Yea		4. RACE	American Indian,	
BY F	1 Never Married 2 Married 3 Midowed 4 Divorced	YES 2 0	40	If yo	s, specify	Cuben, Mexica NO Specif	in, Puerto	Rican, etc.)		Black, V	nita, atc.		
- 1	15. DECEDENT'S E	16a. DE	CEDENT'S	USUAL OCCU	PATION		16	b. KIND OF BUS	SINESS/INDU		lle		
COMPLETED	(Specify only highest gri	(G life.	live kind of v Do NOT us	vork done duri e retired.)	g most of	working							
MP	unknown		oper	rator				conces					
	17. FATHER'S NAME (First, Middle, Last) Harry C. Springe							Middle, Maiden					
BE	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS (S	met and N	lumber or Burni	Onurba Alvin	aber City or Town	n State 7in C	Cordel	-	
2	196. INFORMANT'S NAME (Type/Print) Betty Lerch 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 119, Rohrersville, Md. 21779												
	20e. METHOD OF DISPOSITION t Ø Suriel 2 ☐ Cremetion 3 ☐ R	emoval from State	20b. PLACE	AND DATE	OF DISPOSITION	N (Name o	of	DA		CATION — CI			
	4 ☐ Donation 8 ☐ Other (Specify)		Beau	tifui			. 3-1-			te Li	ne, N	lary land	
	· 500	Mun	neck	2			DDRESS OF FA H FUNE Wilson		HOME d.,Hage	erstou	m, Md	. 21740	
	23. PART I. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, interval Bellonset and Onset and												
CERTIFICATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DIM TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
BITIE	reaulting in death) LAST	PERFORMED? AMAILAE											
AL	PART II. Other significant condit	ons contributing to do	eath but not a	resulting	In the unde	iying ca	iuae given in	Part I.	PERFOR	MED?	AN	AILABLE PRIOR TO	
MEDICAL	PART II. Other significant condit	ons contributing to do	My fa	resulting	in the unde	lying ca	iuae given in	Part I.		MED?	- AN	AILABLE PRIOR TO	
MEDICAL	PART II. Other significant condit	ons contributing to divide the second to the second the	eath but not a	resulting			OF DEATN (Ch		PERFOR	MED?	- AN		
SICIAN: MEDICAL	PART II. Other significant condit	HOSPITAL:	Oly fa	DOA	OTHER 47 Muraing	6 PLACE	OF DEATN (Ch	s Oth	PERFOR 1 VES 2 Pre) Pre (Specify)	MED?	AN CC OI	AILABLE PRIOR TO IMPLETION OF CAU DEATH?	
PHYSICIAN: MEDICAL	PART II. Other significant condit	HOSPITAL: 1 Inpettent 2 E 28a. DATE OF IN (Month, Day.	SILVER/Outpatient 3	DOA DOA	OTHER 40 Nursing E OF 28	B PLACE Home 5 INJURY WORK?	OF DEATN (Ch	s Oth	PERFOR 1 VES 2	MED?	AN CC OI	AILABLE PRIOR TO IMPLETION OF CAU DEATH?	
ED BY PHYSICIAN: MEDICAL	PART II. Other significant condit	HOSPITAL: Inpetient 2 E 28e. DATE OF IN 28e. PLACE OF	Mr fts ER/Outpetlent 3 JURY Year) INJURY — At ho	DOA DOA INJ	OTHER!	Home 5 INJURY WORK?	OF DEATN (Ch	s Oth	PERFOR 1 VES 2 Pre) Pre (Specify)	NJURY OCCU	AN CX OI 1	AILABLE PRIOR TO MPLETION OF CAL	
ETED BY PHYSICIAN: MEDICAL	PART II. Other significant condit L. C. C. C. C. C. C. C. C. C. C. C. C. C.	HOSPITAL: 1 Input ent 2 E 28e. DATE OF IN (Month, Day. 28e. PLACE OF building, etc.)	ER/Outpetlent 3 UNY fac ER/Outpetlent 3 UJURY Year) INJURY — At ho C. (Specify) y knowledge, de	DOA 28b. TIM INJ	OTHER: 4 duraing E OF 28 URY M street, factory,	B_PLACE Home 5 .: INJURY WORK? YES office	OF DEATN (Ch	s Oth 28d. DE 28t. LO	PERFOR 1 YES 2 1 YES 2 1 (Specify) SCRIBE HOW II CATION (Street a ror Town, State)	NJURY OCCU	AM CROOK	MILABLE PRIOR TO MIPLETION OF CAL DEATH? YES 2 2 NM	
TED BY PHYSICIAN: MEDICAL	PART II. Other significant condit L. C. C. C. C. C. C. C. C. C. C. C. C. C.	HOSPITAL: 1 Inpetient 2 E 28e. DATE OF IN (Month, Day. 28e. PLACE OF building, et	ER/Outpetlent 3 UNY fac ER/Outpetlent 3 UJURY Year) INJURY — At ho C. (Specify) y knowledge, de	DOA 28b. TIM INJ	OTHER: 4 duraing E OF 28 URY M street, factory,	B_PLACE Home 5 .: INJURY WORK? YES office	OF DEATN (Ch	s Oth 28d. DE 28t. LO	PERFOR 1 YES 2 1 YES 2 1 (Specify) SCRIBE HOW II CATION (Street a ror Town, State)	NJURY OCCU	AM CROOK	MILABLE PRIOR TO MIPLETION OF CAIDEATH? YES 2 (1) MC	



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

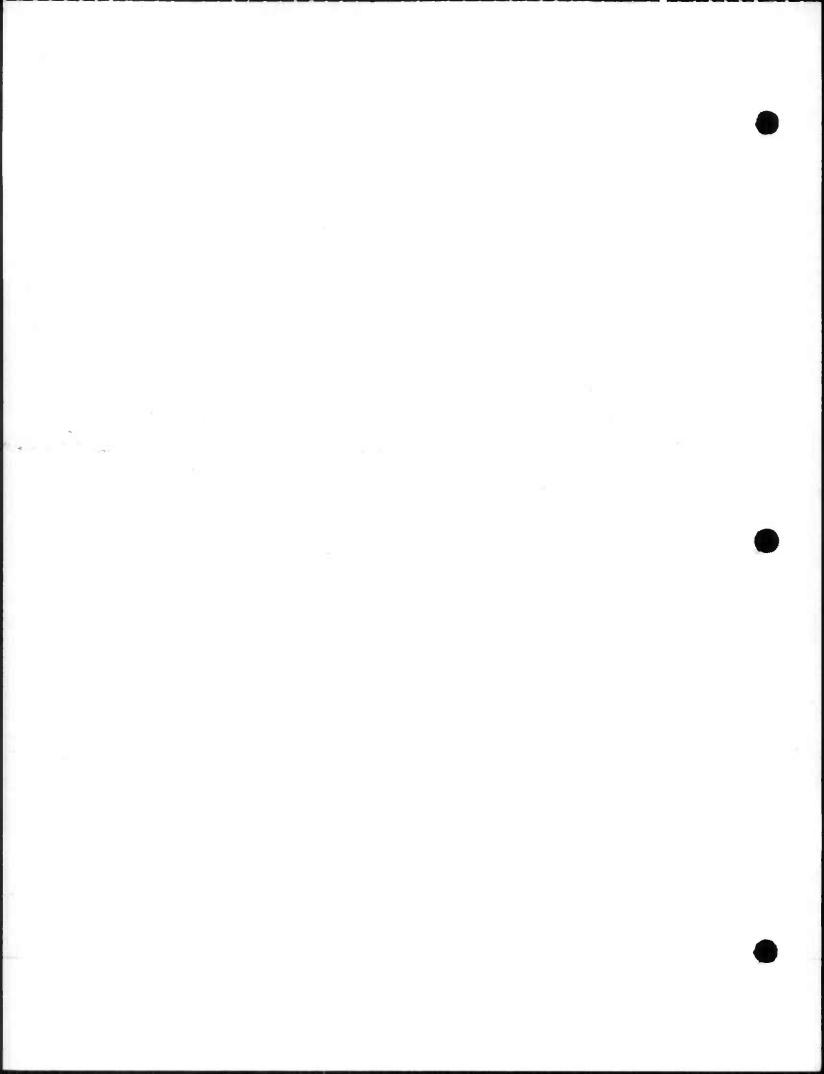
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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

	1 - STATE REGISTRAR	OINTE OF INA	CE	RTIF	ICATE OF	DEATH	AD MICI	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)		·				2.	DATE OF DEATH			TIME OF OEATH	_
	GLENN E.	GEYER, S	SR				- '	2 19	DAY	95 2	:05pM	М
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 F	IRS. 7. I	DATE OF BIRTH		& DISTUSI A	CE /State or Familia	
	217-18-7501	1 🛚 M 2 🗆 F	7 2	YRS.	MONTHS DAYS	HOURS	III. 2	(Month, Day, Year) 28/22		OUINC	Y, PA	
ij	9a. FACILITY NAME (If not institution, give s		-		9b. CITY, TOWN	OR LOCATION		, ,		NTY OF DEATH		
OH	WASHINGTON COUN	NTY HOSPI	ITAL		HAGE	RSTOWN	V		WA	SHING	TON	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT											_
E		DERICK			Y, TOWN OR LOC. ERSVIL					10d	INSIDE CITY LIMITS?	
	100. STREET AND NUMBER	MI							YES 2 NO			
RA			1	of. ZIP CODE	2		ZEN OF WHAT					
FUNERAL	2029 CANADA I			21773			<u></u>	US				
品	1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	TYES 2 N	O	tt yes, s	pecify Cuban, M	laxican, Pu	RIGIN? (Specify Ya	s or No	14. RACE — A Black, Wh	kmerican Indian, ilta, etc.	
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR	WWII		1 🗆 YE	s XXXNO	Specify			Specify:	WHITE	
ED	15. DECEDENT'S EDU	CATION	16a. DEC	EDENT'S	USUAL OCCUPAT	ION		16b. KIND OF BU	ISINESS/INC	DUSTRY		_
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Giv	re kind of a Do NOT us	vork done during n se retired.)	ost of working						
AP.	11		PRE	SSM.	AN			PRINT	ING	FIRMS		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							First, Middle, Maider				
BE (ALBERT A. GEYI	<u> </u>				ELS	SIE	McFERR	EN			
10	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS (Street	and Number or I	Rural Route	Number, City or Toy	vn, State, Zip	Code)	VD 0477	7.7
-	HELEN P. GEYE			029	CANAD	A HILI	L KD	, MYE	RSVI	LLE,	MD 2177	13
	20a METHOD OF DISPOSITION XX Buriel 2 Cremetton 3 XRam	oval from State	20b. PLACE A	ND DATE	OF DISPOSITION (lame of				City or Town, S		
	4 Donation 5 Other (Specify)		Qυ	INC	Y CEME					, PA		
) .			22. NAME /	ND ADDRESS (OF FACILIT	GROVE	FUNEF	RAL HON	Æ, INC	
	Camea H.	Soulerson			50 S	BROAD	ST.	WAYNESE	ORO I	A 1726	8	
	23. PART (VEnter the diseases, Dr	complications that co	sused the dea	th. Do r							Approximate	
	ahock, or heart failure. IMMEDIATE CAUSE (Final	Liet Dnly Dna cause	on sach line.								Interval Betwee Onset and Daat	
disease or condition resulting in deeth) a. ACUTE RESPIRATORY FAILURE								į				
	resolding in deedly	DUE TO (OF	DUE TO (OR AS A CONSEQUENCE OF):									\dashv
Z	FMPHYSFMA											
E	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											\neg
2	CAUSE (Disease or Injury	c CORONAL										
Ë	that initiated evente resulting in death) LAST	DUE TO (OF	AS A CONSEC	UENCE OF	7):					i		
CERTIFICATION		d										_
DICAL	PART II. Other significent condition	s contributing to de	eth but not re	sulting i	n the underlyi	g ceuse give	n in Part	I. 24a. WAS AN			E AUTOPSY FINDINGS	is
2								PERFO		COM	LABLE PRIOR TO	
ME		_							20		YES 2 NO	
ž	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEAT	'H YE	S I NO [UNCER	TAIN D	X				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEAT	H (Check only one)						\dashv
Sic	1 TES 2XXNO	HOSPITAL:	VOutpatient 3	□ DOA	OTHER: 4 Nursing Ho	ne 5 🗌 Reside	nca 6 🗆	Other (Specify)				\neg
E	27. MANNER OF DEATH	28a. DATE OF INJ (Month, Day,		28b, TIM		JURY AT ORK?	26d	. DESCRIBE HOW	INJURY OC	CURED		\exists
BY	1 Natural 5 Pending 2 Accident Investigation					YES 2 NO	0					
	3 Suicide 6 Could not be	28a. PLACE OF IN building, stc.	IJURY — At hor	ie, term, s	treet, factory, offi	ca	28t.	LOCATION (Street City or Town, State		or Rural Route	Number,	ᅦ
	4 Homicide determined							Only or lown, orașe	/			
PL	29e. CERTIFIER 1XXCERTIFYING PHYSI	CIAN: To the best of my	knowledge, dea	th occurre	d at the time, dat	and place, and	due to th	e cause(e) end ma	nner se stat	ed,		
COMPLETED	one) 2 MEDICAL EXAMINE										manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIE			_		29c. LICENSE				E SIGNED (Mon		\dashv
BE	L1)imaht	Maga	(01)			D220			•	/19/95		
2	30. NAME AND ADDRESS OF BERSONAWH	O COMPLETED CAUSE (OF DEATH (ITEM	27) (Туре,	Print)					-/ ± 2/ 7.	,	\dashv
	L. DWIGHT WOOSTE		HOWELL	RD,	HAGERS	TOWN I	MD 2	21740				
1	31FEB 2 2 1995" Jul	12 REGISTRARY										٦
- 1		THE BAY BALLINGSAMEST WAS A	nothing on \$12									- 1



be retained by the hospital or attending physician. , MARYLAND 21215-0020

DIVISION OF VITA! DECODE

BOA 66/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thousand the death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	r traumatic event, the medical examiner must be notified at once.
CIVISION OF VITAL AECONDS, F.O. BOX 66/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certific:	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

											9	5	17805	
	1 - FOR STATE REGISTRAR	STATE OF N		DEPAR						HYGIEN REG. NO	_			
	1. DECEMENT'S NAME (First, Middle, Last)	1	^	,					2. DATE OF MONTH	DEATH	NY NY		3. TIME OF DEATH	
	Ronald Sig	1 Veste							02	ã		95	0805 M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is		IF UNDE	DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, De	BIRTH sy. Year)		Country)	LACE (State or Foreign	
	213-24-9486	1 2 M 2 - F	66	YRS.					Sep. 28	B, 192		Mary	land	
ا <u>م</u> ا	9e. FACILITY NAME (If not institution, give st		- 1		9b. CIT		R LOCATIO		EATH		1	NTY OF DEA		
[6	Washington Count	y Hospit	aı			На	gerst	own			Wa	shing	jton	
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN	OR LOCAT	ION			-		10d. INSIDE CITY			
	Maryland Washi	ngton		5	har	osbur	· g					1	LIMITS?	
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODI	E			10g. CIT	IZEN OF WH	IAT COUNTRY?	
🖫	2411 Dargan Rd.						217	82			US	Α		
5	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT	EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (S	pecify Yee	or No-	14. RACE -	- American Indian, White, etc.	
ВҰ	3 Widowed 4 Divorced	IF YES, GIVE W					2 🔀 NO			ii, atu.j		Specify:		
	15. DECEDENT'S EDUC	CATION	16a Di	ECEDENT'S	HEHAL (ACCUIDATIO	\w\.		I day ten				White	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +		Sive kind of a	work done	during mo	st of workin	g	160. KJP	4D OF BUS	SINESS/IND	JUSTRY		
7	9	College (1-4 or 5 +		r Mar					F	Railr	oad.			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NA	ME (First, Middl					
BE C	Clarence Do	uglas	Grim					Dor			eda	J	amison	
10 B	19e. INFORMANT'S NAME (Type/Print)		16	b. MAJLING	ADDRES	S (Street a	nd Number	or Rural I	Poute Number, (City or Town	n, State, Zip			
F	Hattie V.Grim			2411	Darg	gan F	₹d.	Shar	psburg	burg,MD 21782				
97	20e. METHOD OF DISPOSITION 1 M Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Cample of													
	4 Donation 5 Other (Specify)		Sample	s Mano	r Ce	neter	/ Feb	.24,	1995	Shai	rpsbu	urg, MC	21782	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE						D ADDRES	S OF FA	RAL HON	ΛF				
100	11/14/1/1/	Malu-		_					Willi	-	ort	MD 21	705	
	23. PART I. Enter the diseases, or c	omplications that	caused the de	eath. Do r	ot ente	r the mo	de of dyl	ng, suc	h es cerdiac	or reepi	ratory en	rest,	Approximate	
	ahock, or haart fallure. I IMMEDIATE CAUSE (Finel	lat only one cau	se on aach line	D.									Interval Between Onsat and Death	
	disease or condition resulting in death)	Co.	ngesti	ve ,	Rea	N	Fai	Mu	Le,				2 YRS	
			OF AS A CONSE	OUENCE O	F):								7/25	
N	Sequentially list conditions,	Cong	OR AS A CONSE	Ca	role	on	top	ath	7				SYRS	
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	lon l	OR AS A CONSE	QUENCE O	F):		_	100					77 10	
5	CAUSE (Disease or injury	DUE TO	OR AS A CONSE	OUENCE OF	he	arr	d	180	ase				3 yrs	
	that initieted events resulting in deeth) LAST		ON NO N CONSE	QUEITOE O	,.									
E		·											İ	
¥	PART II. Other significant conditions	contributing to	deeth but not	resulting i	n the u	nderlying	cause g	lven in	Part I. 24s	. WAS AN			VERE AUTOPSY FINDINGS	
MEDICAL	<i>D</i>	rabeles	c me	111 10	45				10	YES 2	1	0	OMPLETION OF CAUSE	
¥										/			YES 2 NO	
ä	DID TOBACCO USE CONTR	IBUTE TO CA					UNC	ERTAIN	1 13					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF OEAT	OTHE									
IYS	1 VES 2 NO 27. MANNER OF CEATH	1 M Inpatient 2 M		_	4 🗆 Nu	rsing Hom		aldence	6 Other (Sp					
	1 Matural 5 Pending	28e. OATE OF (Month, Da	ly, Year)	28b. TIM	E OF URY		RK?		28d, DESCRI	BE HOW IN	JURY OCC	CURED		
B	2 Accident Investigation 3 Suicide	28e. PLACE OF	INJURY — At he	ome form	tract for		ES 2 _	NO	761 1 001710	A1 (D)	1.44 - 4			
E	4 Homicide determined	building,	etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	ineet, iec	tory, office	,		26I. LOCATIO City or To	wn, State)	na Number	or Hural Hou	ite Number,	
ÉT	29a. CERTIFIER 1 CERTIFYING PAYER	MAN. To the best of				(To 2 P								
COMPL	(Check only one) 2 MEDICAL EXAMINER													
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER				, my					prace, end				
BE	The or CENTIFIER						D LL						fonth, Day, Year)	
2	D44996 ► 2-21-95													

MD

BOONSBORD

21713

DHMH-16 Rev 1/89

San Sant To the Little Co

2. DATE OF DEATH

February

7. DATE OF BIRTH

17,

1995

9c. COUNTY OF DEATH

BALTIMORE, MARYLAND 21215-0020

1 - STATE REGISTRAR

Raymond

4. SOCIAL SECURITY NUMBER

31. DATE FILED (Month, Day, Year)

2.4

1995

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. I	INCOPTAL DO ATTENDIAL DIAVELLIAM. The face show the death partitioned by according to
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1 N 2 F 78 Jun 26 1916 226-28-9237 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Calvert Memorial Hospital Prince Frederick 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Calvert Solomons permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 13325 Dowell Road 20688 hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TYES 2 XNO Specify ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Worker State Highway Adm. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) after death. Page 6 may be retained by the William Guthrie Nancy notified 19e. tNFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joyce Guthrie 1600 Ball Road Port Republic, MD 20678 pe 20a. METHOD OF DISPOSITION
1 X Buriel 2 Cremetion 3 1 He 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Seventh Day Adventist Cem 2-21-95 Cumberland Co. VA 4 Donation 5, Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, PA Owings, MD 20678 and completely filled in by the burial, cremation, or removal. 23, PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition Kespiratoom event. resulting in death) DUE TO (OR AS & CONSEQUENCE OF): prior to burial. traumatic CERTIFICATION Sequantially list conditions. DUE TO (OR AS If any, leading to immediate signed by the attending physician Health and Mental Hygiene prior to cause. Entar UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF) that initiated evants resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY disease, Parkinsons Dementia shows any 1 TYES 2 NO t. of h PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: 1 TES 2ND NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED this ca marked. 1 Natural 5 Pending 1 YES 2 NO 8 After death 2 Accident Investigation 28a. PLACE OF INJURY — A1 home, term, street, factory, offica building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 COMPLETED 6 Could not be DIRECTOR: / 4 Homicide 28 determined TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT: If Item 2 29a. CERTIFIER

(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the filme, date and piece, and due to the cause(a) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Lun Jonson 27189 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Z. Yousaf M.D. 100 Hospital Road Prince Frederick MD.

> 32. REGISTRAR'S SIGNATURE Talia Davidson Rardall

Delbert

6. AGE (In yrs. last birthday)

YRS.

5. SEX

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Guthrie

DAYS

IF UNDER 1 YEAR IF UNDER 24 HRS.

HOURS

MIN.

95 07806

3. TIME OF DEATH

15:42

10d. INSIDE CITY LIMITS?

1 YES 2 NO

White

Approximate intarvai Batween

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

20678

Onset and Death

6. BIRTHPLACE (State or Foreign

Calvert

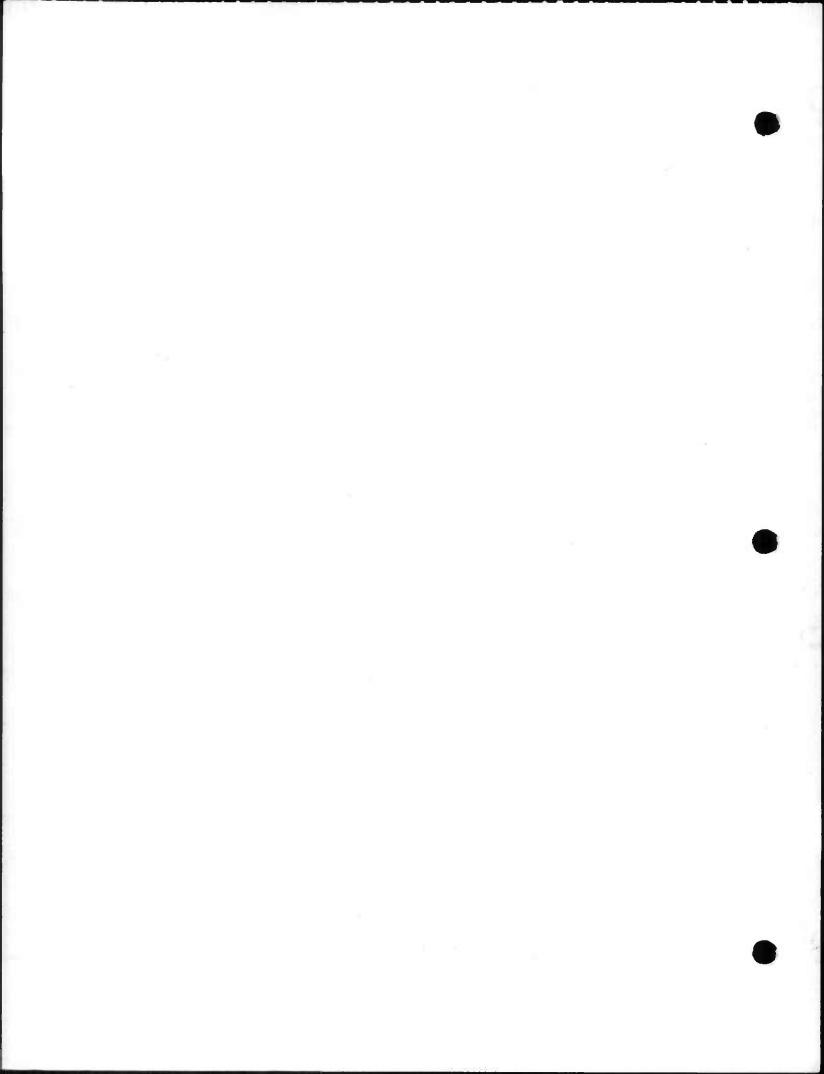
10g. CITIZEN OF WHAT COUNTRY?

Specify:

Huddleston

U.S.A.

14. RACE — American Indian, Black, White, atc.



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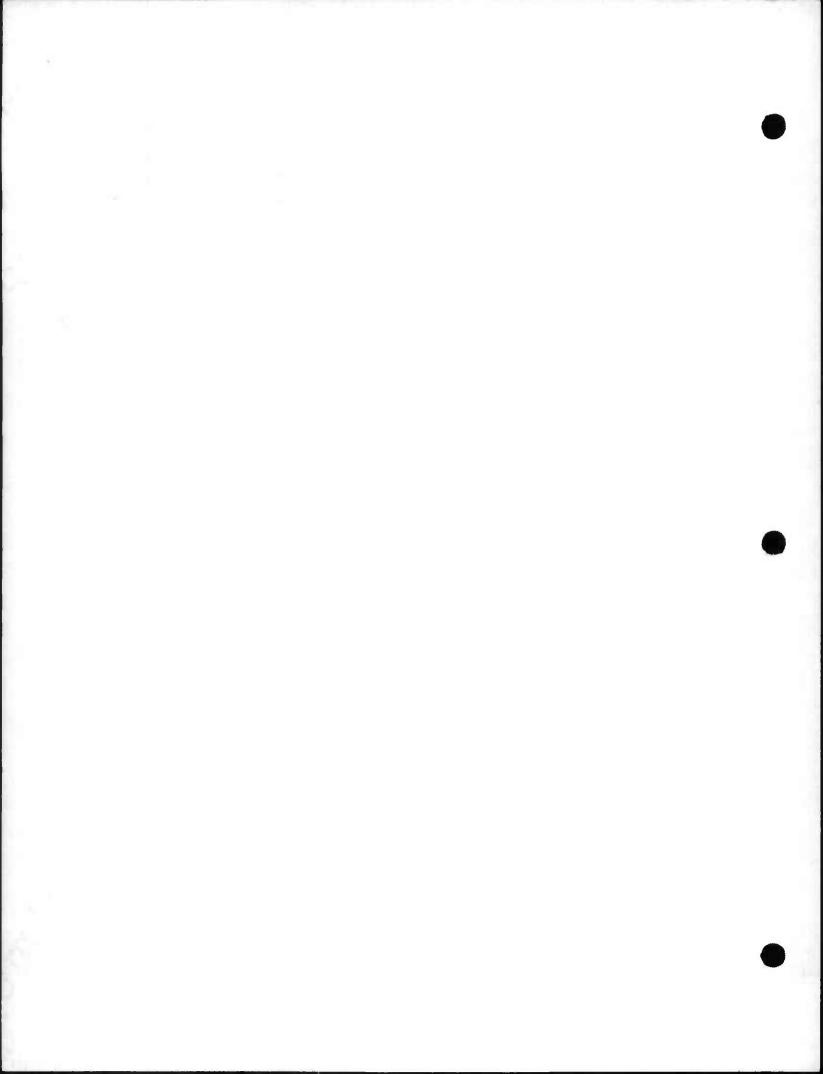
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PHYSICIAN: The law requires that the	r this certificate has been signed by the h with the State Dept. of Health and M
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Ellwoo Burton 1220 630N 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Morith) Day, Year 9 9 8. BIRTHPLACE (State or Foreign Country) 1 M 2 D F 6 216-32-9331 YRS 3 MD 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH 5706 DIRECTOR rooks othinu RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Lothian 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5713 Little Road 20711 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 YES 2 1 NO Specify Specify 3 Widowed 4 Divorced Korea white BE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe ntary/Sec fary (0-12) College (1-4 or 5+) painter construction examiner must be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Joseph A. Gibson Bernice Moreland 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) Russell F. Gibson 5746 Brooks Woods Rd., Lothian, MD 20711 20a. METHOD OF DISPOSITION

1 N Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Maryland Veterans Cem, 2/28/95 Cheltenham, MD 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mean Rausch Funeral Home, P.A. Owings, MD 7 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such sa cerdiec or respiratory screet, shock, or heart failure. List only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition_ 9.5. CND. resulting in death) IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, BY PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be determined 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and my 8 29d, DATE SIGNED (Month, Day, Deputy (mice) D 0605 2 MPLETED CAUSE OF DEATH (ITEM 27) (Type, Pres)

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nours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 23

		FOR												95	078	08
		1 - STATE REGISTRAR			MARYLAND C	/ DEPAR ERTIF	TMENT	OF I	DEA	AND I	MENTAL	HYGIEN REG. NO	_			
	i	1. DECEDENT'S NAME (First, Middle, Last) Wayne Robert Wayner Greathouse 2. DATE OF COMMUNITY Feb.								TH DAY YEAR		3. TIME OF 0				
		4. SOCIAL SECURITY NUME	_	5. SEX	6. AGE (in yrs. le		IF UNDER		IF UNDER	1	7. DATE OF				HPLACE (State of	
		216-70-7949		1 □XM 2 □ F	36	YRS.	MONTHS	DAYS	HOURS	MIN.	Dec.	25,		Ma	aryland	Ē
"		98. FACILITY NAME (If not institution, give street and number) 9203 Dixon Drive							OR LOCATI	ON OF DE	EATH			INTY OF E		l a
ָ טַ		RESIDENCE OF DECEDENT														
DIRECTOR		Maryland	Mont	tgomery			aithe								10d. INSIDE	
	- 15	10m. STREET AND NUMBER	1.011	eganery	····	1 00	<u> </u>		I. ZIP COD	E			10g. CIT	TIZEN OF	1 TYES 2	
FUNERAL		607 Coral	Reef I	Drive					2087	77			Į	J.S.	A.	
J.		11. MARITAL STATUS 1 Nover Married 2	Married	FORCES?	T EVER IN U.S. A	RMED NO	l H	yes, sp	ecify Cubi	ın, Mexica	IIC ORIGIN?		s or No-	14. RAC	E — American k, Whita, etc.	Indian,
Ä		3 Widowed 4 Dive		IF YES, GIVE	WAR OR DATES		1	YES	2 XNO	Specify	y:			Cauc	tasian	
TED		15. DECEDENT'S EQUCATION 16a. OECEDEN (Specify only highest grade completed) (Give kind				ECEDENT'S Give kind of	work done d	CUPATIO	ON ost of world	ng	16b. K	IND OF BU	SINESS/IN	DUSTRY		
once.		Elementary/Secondary (0	1-12)	College (1-4 or 5	+)						700	+	4-1			
OM O		12 2 Salesman 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME						Itomo								
ed at (Donald Greathouse Sara								Morri	ison					
TO E		19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AGORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Workman 4543 A. Rawlings Place Waldorf, Md 206								502						
must b		20a, METHOD OF DISPOSIT. 1 □ Burlal 2 □ Crematic 4 □ Donation 5 □ Other	on 3 🗆 Ram	noval from Stata	20b.PLACE cometery.cr Herit	AND DATE	OF DISPOSI	TION (No	ama oi	/larch	1 1% TE	20c. LC	CATION -	City or To		1
examiner must be notified at once.		21. SIGNATURE OF FUNERA	A A	CENSEE	t		22.1	AME A	ND ADDRE	SS OF FA	CILITY	Lee :	Funer	cal H	Iome, I Inton,	nc.
other traumatic event, the medical		23. PARTY. Enter the di shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eert fellure.	complications the List only one ce	DAVC		nic	the mo	CAC	Ing, auc	1207.73 F	c or reap	iratory ar	reet,		kimate il Between and Death
TIFICATION		Sequentially list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):														
icA Iza		cause. Enter UNDERLY! CAUSE (Disease or Inju	ING	C.	/OD 45 4 CONS	FOURNOE O										
5 E		that initieted events resulting in deeth) LAS	T	d	OR AS A CONSI	EGUENCE U	r).									
		PART II. Other significe	ent condition	ne contributing to	deeth but not	reculting	in the un-	derlyln	g ceuee	given in	Part I. 2	4a. WAS AN		246	. WERE AUTOPS	Y FINDINGS
₹	ı										_	PERFO			AMILABLE PR COMPLETION OF DEATH?	
M M															1 TYES 2	NO
2 Z		DID TOBACCO		CONTRIBUTI	TO CAU	SE OF	DEAT		ES [NO						
SICIAI		EXAMINER?	O WEDICAL	HOSPITAL:	FR/Outpatient	3 [] DOA	OTHER	1:	-		eck only one)	D#-1				
marked, or BY PHY:		27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Ver) (Month, Day, Ver) (Month, Day, Ver) 28b. TIME OF NJURY 28d. DESCRIBE HOW INJURY OCCURED INJURY WORK?														
5 D		2 Accident Investigation 3 Suicide 6 Could not be detarmined detarmined 4 Homicide Market						and Numbe	or or Rural	Route Number,						
Item 2	- U	29a. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best o	f my knowledge, d	leath occur	red at the file	me, data	and place	, and due	to the cause	e(a) and me	nner as ste	ited.		
= =		onel -		ER: On the besis of a											a) and manner	aa stated.
PORTANT: BE CO!	- 11	296. SIGNATURE AND THE	СЕНТІРІЕ	n O					290 LIC	ENSE NUI	ABER 1		29d. DA	TE SIGNE	(Month, Day,)	þar)

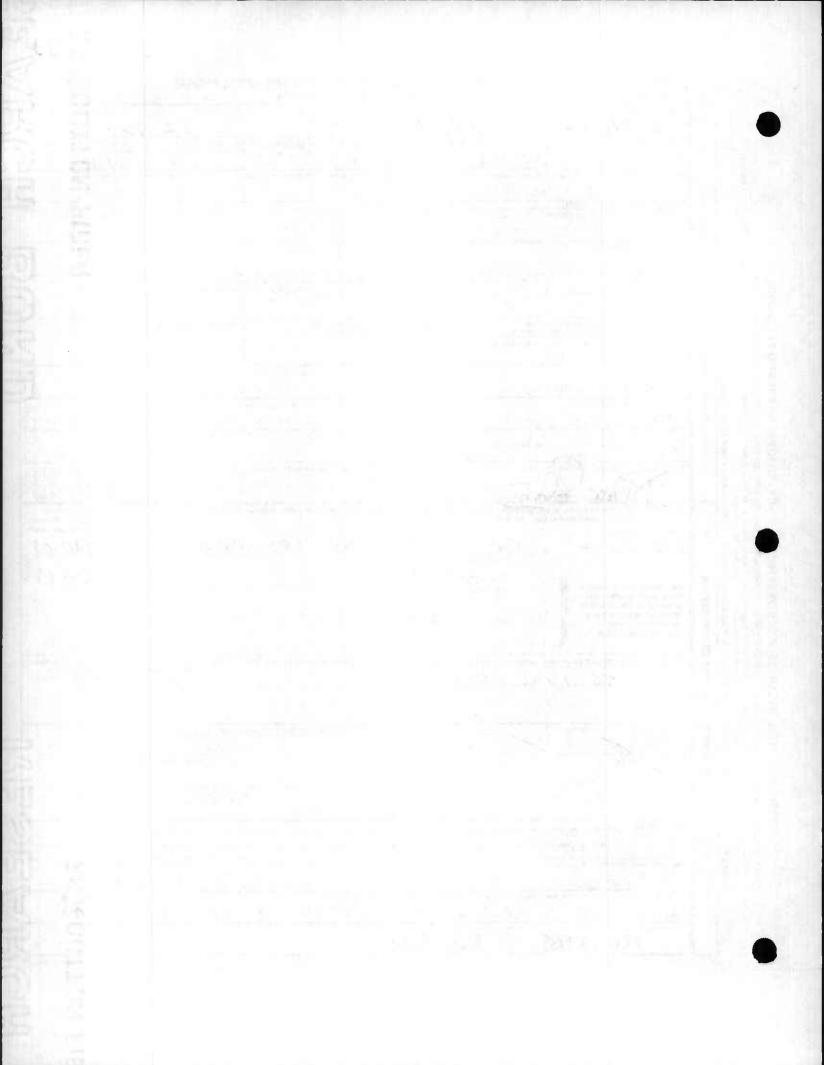
29a. CERTIFIER 29d. DATE SIGAEO (Month, Day, Year) 15 Frank M. Ryan
31. DATE FILED (Month, Day, 1601)
FEB 2 8 19 6188 .D Oxon Hill Road #610 Oxon Hill Md. 20745-3113 32. REGISTRAR'S SIGNATURE
Fully d'Audion Randell

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	1. DECEDENT'S NAME	OVAN		Farrent	ANN/			DEATH	2. DATE OF DEATH DAY Z Z		AY	2-95	12:48P
	4. SOCIAL SECURITY N 216-28-59	NUMBER	6. SEX	6. AGE (In yrs. Ia	et birthday) YRS.	IF UNDER 1 Y	EAR AYB	IF UNDER 24 HRS. HOURS MIN.	(Monti	OF BIRTH h, Day, Year)		8. SIRTNPL Country)	LACE (State or For
		9a. FACILITY NAME (If not institution, give street end number)				9b. CITY, TOWN OR LOCATION OF DEA					yland		
OR	Anne Arundel Medical Center				Anna	apo	lis			Anne	Aru	ndel	
ECTO	RESIDENCE OF	DECEDENT 10b. COUNT	ry		10c. CIT	Y, TOWN OR L							Od. INSIDE CITY
DIR	MD	MD Anne Arundel						onville					LIMITS?
AL	10a. STREET AND NUM	ISER						ZIP CODE			10g. CITIZ		AT COUNTRY?
ER	3577 Queen Anne Bridge Road						21035			Unit	ed S	tates	
BY FUNER	11. MARITAL STATUS 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 ☐ YES 2 ☑ IF YES, GIVE WAR OR DATES				ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No-					14. RACE - Slack, \	- American India White, etc. White		
ED		DECEDENT'S EDL		16a. Di	ECEDENT'S	USUAL OCCU	PATIO	IN of working	16b	. KIND OF SU	SINESS/INDL		
COMPLET	Elementary/Seconds		College (1-4 or 5	116	. Do NOT u	se retired.)	ng mos	st or working			t,,		
MP	17. FATNER'S NAME (First, Middle, Last)				ivied					Automobile			
	Donovan I		away. Sr			18. MOTNER'S NAME (First, Middle, Meiden Sum Kathryn Wayson				,	urname)		
BE	19a. INFORMANT'S NAI			16	b. MAILING	ADDRESS (S	treet er	nd Number or Rural				Code)	
2	Esther Y. Gannaway 3577 Queen Anne Bridge Road Davidsonville,								e. MD 2				
	20s. METHOD of DISPOSITION DATE 20c. LOCATION — City or Town, State 2 Cremetton 3 Chemoval from State 2 Commetton 6 Chemoval from State 2 Chemoton 5 Chemoval from State 2 Chemoton 5 Chemo								aryland				
	147 Duke of Gloucester St. Annapolis, M. 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	23. PART I. Enter th	ne disesses, or	complications the	at caused the d	eath. Do								olis, N
	23. PART I. Enter the shock, a shock, a shock, a shock, a shock, a shock and shock as the shock	or heart fellure. (Finel	a. CA	no on each lin	MSC	ULA	s mod		h ss care	disc or resp			Approximatinterval But Onset and
	IMMEDIATE CAUSE disease or condition	or heart fellure. (Finel	a. CA	O (OR AS A CONSE	OUENCE O	ULA	s mod	de of dying, euc	h ss care	disc or resp			Approximinterval B
ERTIFICATION	IMMEDIATE CAUSE disease or condition	or heart feilure.	a. DUE TO	no on each lin	OUENCE O	ULAV	s mod	de of dying, euc	h ss care	disc or resp			Approximinterval B
MEDICAL CERTIFICATION	shock, immediate cause if eny, leading to in cause. Enter UNDE CAUSE (Disease or that initiated event resulting in death) PART II. Other sign	or heart fellure.	a. Due To b. Due To c. Due To d.	O (OR AS A CONSE	SOURNCE OF	not enter the	s mod	de of dying, euc	h ss card	disc or resp	AUTOPSY	24b. W	Approximinatival Books and Double Books
AN: MEDICAL CERTIF!	shock, IMMEDIATE CAUSE disease or conditio resulting in death) Sequentisity list co if eny, leading to in cause. Enter UNDE CAUSE (Disease or that initiated events resulting in death) PART II. Other sign	or heart fellure.	b. DUE TO C. DUE TO d	O (OR AS A CONSE	COUENCE OF	not enter the	s moo	de of dying, euc	Part I.	24a. WAS AN PERFOR	AUTOPSY	24b. W	Approximinterval Be Onset and DOUTE AUTOPSY FILMILABLE PRIOR
PHYSICIAN: MEDICAL CERTIFI	shock, immediate cause disease or condition resulting in death) Sequentially list confidence in the cause. Enter UNDE CAUSE (Disease or that initiated events resulting in death) PART II. Other sign 25. WAS CASE REFERE EXAMINER? 1 YES 2 RO 27. MANNER OF DEATH 1 Netural S	or heart fellure.	a. DUE TO b. DUE TO c. DUE TO d	O (OR AS A CONSE	COUENCE O	OTHER: 4 Nursing	s mod	J couse given in	Part I.	24a. WAS AN PERFOI	AUTOPSY RMED?	24b. W A C C O 1	Approximinatoral Book Onset and DOWNER AUTOPSY FI
ED BY PHYSICIAN: MEDICAL CERTIFI	shock, immediate cause disease or condition resulting in death) Sequentially list confidence in the cause. Enter UNDE CAUSE (Disease or that initiated events resulting in death) PART II. Other sign 25. WAS CASE REFERE EXAMINER? 1 YES 2 RO 27. MANNER OF DEATH 1 Natural S 2 Accident	or heart fellure. (Finel on heart fellure. (Finel on heart fellure. Indicate fellure. (Finel on heart fellure. (Finel	B. DUE TO DUE	O (OR AS A CONSE	COUENCE OF COUNCE OF COUN	OTHER: 4 Nursing	s moo	J ceuse given in ACE OF DEATH (Ch	Part I.	24a. WAS AN PERFOI	AUTOPSY MMEDY NO INJURY OCCI	24b, W. A. C. C. O. 1	Approximinterval B Onset and D
D BY PHYSICIAN: MEDICAL CERTIFI	Shock, IMMEDIATE CAUSE disease or condition resulting in death) Sequentisity list confirmation of the sequentisity list confirmation of the sequentisity list confirmation of the sequentisity list confirmation of the sequentisity lists and sequentisity lists are sequentially lists and sequential	enditions, namediate RLYING Injury LAST Inflicant conditions ED TO MEDICAL S Pending Investigation CERTIFYING PHYS	B. DUE TO DUE	O (OR AS A CONSE	COUENCE OF COUNTY OF COUNT	OTHER: 4 Nursing E OF Street, factory, and at the time.	s mod	J ceuse given in ACE OF DEATH (Ch 5 Residence URKY TES 2 NO end place, end due	Part I. Part I. 6 Other 28t. Loc City	24a. WAS AN PERFORM 1 YES 1 SCRIBE NOW I	AUTOPSY RMED? NO	24b. WARED URED Or Rural Round.	Approximinterval Bionset and Discourse and D

31. DATE FILED (Month, Day, Year)
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Julia Shuckson Randall



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MAR	YLAND / DEPARTMEN CERTIFICAT	T OF HEALTH AND I	MENTAL HYGIENE REG. NO.						
3	1. DECEDENT'S NAME (First, Middle, Lest)			2. DATE OF DEATH MONTH DAY	WEAR	3. TIME OF DEATH				
	JOANN MALONE			2 - 25	- 95 YEAR	3:50 pm				
- 5	016-34-6335 10 M2XF	5 7 YRS. MONTHS	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 5 - 24 - 37	Country)	LACE (State or Foreign				
Œ	9e. FACILITY NAME (if not institution, give street and number)	240	Y, TOWN OR LOCATION OF OE	ATH 9c	. COUNTY OF DE					
DIRECTOR	Jniversity Hospital		Baltimore		N/A					
RE(10a. STATE 10b. COUNTY	10d. NSIDE CITY LIMITS?								
	Maryland Anne Arundel	Mille	rsville			1 YES 2 NO				
RA	10, 21 CODE									
FUNERAL	403 Honeywood Court 11. MARITAL STATUS 12. WAS DECEDENT EV	ER IN U.S. ARMED 13.	21108 WAS DECENDENT OF HISPAN	IIC ORIGIN? (Specify Yes or h	USA 14 BACE	- American Indian,				
BY F	1 Never Married 2 Married FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ES 2 XINO	If yes, specify Cuben, Mexican 1 X YES 2 NO Specify	n, Puerto Rican, atc.)	Black, Specify	White, etc.				
				Honduran	ISPANIC					
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUAL Of (Give kind of work done life. Do NOT use retired.)	during most of working	16b. KINO OF BUSINE	SS/INDUSTRY					
PLI	Elementary/Secondary (0-12) College (1-4 or 5 +)			EEO						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	Personn		ME (First, Middle, Maiden Sum	ame)					
BE	Jaime A. Malone		Hazel	Florence	Hennin	ger				
2	19e. INFORMANT'S NAME (Type/Print)		S (Street and Number or Rural R	loute Number, City or Town, St.	ate, Zip Code)					
·	Kenneth Good	Same as		T						
	ty Burlei 2 ☐ Cremation 3 ☐ Removal from State	20b. PLACE AND DATE OF DISPOS cemetery, crematory or other place) M.t Carmel			ON — City or Town					
	21. SIGNATURE OF PUNEITAL SERVICE ACCUMSEE	Mt. Carmer	Cemetery 2.	- <u>28-95 Lit</u> auty	tlesto	wn, PA				
	· Robert Sc	1 B	arranco and	d Sons Fun	eral H	ome				
	23. PART I. Enter the diseases, or complications that cer	and the deeth. Do not enter	95 Ritchie the mode of dylng, such	HWY Sever	na Par	k MD 2114				
	immediate cause (Final	h sech ilne.				interval Batween Onset and Death				
	disease or condition resulting in death)	SEPSI	S							
	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, Oue TO (OR AS A CONSEQUENCE OF):									
CAT	ceuse. Enter UNDERLYING CAUSE (Disease pr Injury									
TE!		AS A CONSEQUENCE OF):								
SER	d.									
AL (PART ii. Other eignificent conditions contributing to deep	h but not resulting in the un	nderlying ceuse given in i	Pert I. 24a. WAS AN AUTO PERFORMED		VERE AUTOPSY FINDINGS				
DIC				1) YES 2 []		COMPLETION OF CAUSE OF DEATH?				
ME				/		TYES 2 NO				
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL	OF DEATH YES 26. PLACE OF DEATH (Check								
SICI	EXAMINER? HOSPITAL:	OTHE	R:							
PHYSICIAN: MEDIC	27. MANNER OF DEATH 28s. DATE OF INJU (Month, Day, Ye	RY 28b. TIME OF	sing Home 5 Residence (28d. DEŞCRIBE HOW INJUR	Y OCCURED					
ВУ	Netural 5 Pending 2 Accident Investigation	ir) injury	WORK? 1 YES 2 NO							
	3 Suicide 6 Could not be determined 28a. PLACE OF INJ building, alc. (URY — At home, farm, street, fact Specify)	lory, office	28I. LOCATION (Street and N City or Town, State)	umber or Rural Roc	ute Number,				
<u>E</u>										
COMPLETED	(Check only one) CERTIFYING PHYSICIAN: To the best of my k one) MEDICAL EXAMINER: On the best of examiner					and manner as stated.				
ECC	2011 MONATURE AND TITLE OF CERTIFIER		29c. LICENSE NUM		I. DATE SIGNED (A					
TO BI	Alexander MD		P077		2/25	195				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF		- 6- 1	14						
	BARBARA ALEXANDER &	125 GREEN	E 31 10	Paltimore	MD					
	31. DATE FILED (Month, Day, Year) 1995 32. REGISTRAR'S S	Clear-Randall				1				
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. From: after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			EKIIF	ICALE	DEATH	F	REG. NO.		
,	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF MONTH	DAY	YEAR	3. TIME OF DEATH
		Edge Harr					Feb	24	1995	9:20a M
	4. SOCIAL SECURITY NUMBER 214-16-4372	5. SEX 1	6. AGE (In yrs. I	lasi birthday)	MONTHS DA		7. DATE OF I	ынтн У. ^{Маг)} 28 , 1908	8. BIRT	HPLACE (State or Foreign try) Yland
	9a. FACILITY NAME (If not institution, give s	treet end number)			9b, CITY, TO	WN OR LOCATION OF I			COUNTY OF	
e B	Dorchester Gener	al Hospit	tal		Cambridge			Dorchester		
בַ	RESIDENCE OF DECEDENT									
SH		chester		5-5	city, town or location Rhodesdale					10d. INSIDE CITY LIMITS? 1 YES XX NO
	10e. STREET AND NUMBER				odebda	101. ZIP CODE	10g CITIZE		. CITIZEN OF	WHAT COUNTRY?
FUNERAL DIRECTOR	4802 East New Ma	rket Rho	desdale	Road		21659			US	
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S.	ARMED NO.	13. WAS	DECENDENT OF NISPA	DECENDENT OF NISPANIC ORIGIN? (Specify Yes		o- 14. RAC	E — American Indian, k, White, etc.
BY	Never Merried 2 Merried PORCES? 1 YES 2 1 NO IF YES, GIVE WAR OR DATES				10	yes X X NO Spec	m, Puerto Rical	1, 4 (C.)	Spec	w White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			(Give kind of v	USUAL OCCUI	PATION g most of working	16b. KIN	ID OF BUSINES	SS/INDUSTRY	
F	Elementary/Secondary (0-12))	actic	al Nur	SP	Н	ealth	Care		
MO	17. FATNER'S NAME (First, Middle, Last)			18. MOTHER'S NAME						
BE C	Walter J. Baker						Lillie		,	
TO B	19e. INFORMANT'S NAME (Type/Print)		1	19b. MAILING	ADDRESS (Str	eet and Number or Rura	Route Number, C	Olty or Town, Sta	ite, Zip Code)	
F	William B. Edge			P.O.	Box 31	Rhodesdale, Maryland 21659				
	20a, METHOD OF DISPOSITION WXBurlel 2 □ Cremetton 3 □ Rem 4 □ Donellon 5 □ Other (Specify)	oval from State			OF DISPOSITION	Cemetery	DATE 7/28	E o o t	N — City or To	own, State
	21. SIGNATURE OF THERAL SERVICE LIC	CENSEE	Last	11CW	22. NAM	E AND ADDRESS OF F	ACILITY	Last	New Ha	iket, rid.
	· Aliword	emes				mas Funera			Marv1	and 21613
	23. PART V Enter the diseases, or o	complications thet	ceused the c	death. Don						Approximate
	shock, or heert fellure. IMMEDIATE CAUSE (Finel	List Dnly one Ceu	e on eech iir	1						Interval Between Onset and Death
ŀ	disease or condition resulting in deeth)	a. 900	172 1			y edem	1			4 days
,	OUE TO (OR AS A CONSEQUÊNCE OF): TO USE TO (OR									
<u> </u>	Sequentially list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):									
S	CAUSE (Disease or Injury	a Hyp	other	211	a					Sucett
CERTIFICATION	that initieted events resulting in deeth) LAST	bue no	OR AS A CONSI	EOUENCE OF	7):					
Ü		d								-
	PART II. Other significant condition		1 -1		n the under	ying cause given in	Part I. 24s	WAS AN AUTO		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL	Ucult	Renal	taila	R			10	YES 2 X	10	COMPLETION OF CAUSE OF DEATH?
Σ	DID TOP ACCOUNT CONTI	DIDLITE TO CAL	165 05 55							1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTI	KIBUTE TO CAL		_	H (Check only		ИМ			
딣	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:					
ž	27. MANNER OF DEATH	28s. DATE OF	NJURY	28b. TIMI		Home 5 Residence		BE HOW INJUR	Y OCCURED	
BY P	1 Netural 5 Pending 2 Accident Investigation	(Month, Da	y, Year)	INJ		WORK? YES 2 NO				
	3 Suicide 8 Could not be	28e. PLACE OF building, e	INJURY — At h	ome, farm, a	treet, factory,	office	28t. LOCATID	N (Street and Ni wn, Stete)	umber or Rural I	Route Number,
	4 Homicide determined									
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSIC CERTIFYING PNY									a) and manner as stated
- 10	296. SIGNATURE AND TITLE OF CERTIFIER				, , , , , ,	29c. LICENSE NU				
B	Kirsonan	M. Ha	DAL 1	no		D-U	3707	290	2/21	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO					10	,,,,		1	
	Rosemary M. Har				Byrn	Street (Cambrid	ge, MD	2161	3
	31. DATE FILED (Month, Day, Year) FR 2. 7 1995	AUDIA OF HERUSTRIA	LOT NAVOS	Ц,						

hours after death. Page 6 may be retained by the hospital or attending physician. And in by the tuneral director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020 executed with

permit. Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	afe	8	d	-
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely fill	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	IMPORTANT: It liters 28 is marked, or Item 23 shows any injury, or other traumatic event, the
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95 07812 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN CECILIA 11:30P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🗆 M 2 屎 F DAYS HOURS MIN. 217-38-8430 YRS AUG. 12 66 1928 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 4158 MUDDY CREEK ROAD HARWOOD ANNE ARUNDEL RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY MARYLAND ANNE ARUNDEL HARWOOD 1XX YES 2 □ NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4158 MUDDY CREEK ROAD 20776-9541 IISA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married Specify: BLACK 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 7th NURSE ASSISTANT CROWNSVILLE HOSPITAL 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) JOSEPH L. FORD ELIZABETH FLEET 19a. INFORMANT'S NAME (Type/Print, 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 4158 MUDDY CREEK RD. HARWOOD, MD. 20776-9541 LEONARD GREEN 20e. METHOD OF DISPOSITION ∜CKBurlat 2 ☐ Crematton 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State CHEWS CHURCH CEMETERY 4 Donation 8 Other (Specify) 3/6/95 OWENSVILLE. MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. Rees avry WEST ST. ANNAPOLIS, MD. 21401 821 23. PART I. Enter the disease, or complications that caused the desth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, of heart fallure. Liet pnly one cause on each line. interval Betw IMMEDIATE CAUSE (Fine) Colon Cancor Onset and Death disease Dr condition ear resulting in death) DUE TO (OR AS A CONSEQUENCE OF Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one,

EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)

4 ☐ Nursing Nome 5 Residence 6 ☐ Other (Specify) 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED

1 YES 2 NO

28s. PLACE OF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town. State)

29s. CERTIFIER

(Chack only Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as attend.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in	ny opinion, death occured at the time, dar	te and place, and due	to the cause(a) and manner as stated

SIGNATURE AND TIT	LE OF CENTIFIER	A	- 1
Po Vo.	- //	120	(hus
I	CVA	Com	Jiv

29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
7	h 0//

									-		
39	AME AND	ADDRESS	OF PERSON	WHO	COMPLETED	CAUSE	OF D	EATH	(ITEM 27)	(Туре,	Print)

1-0 11653

Ĺ	FTER	F	YER	Koun

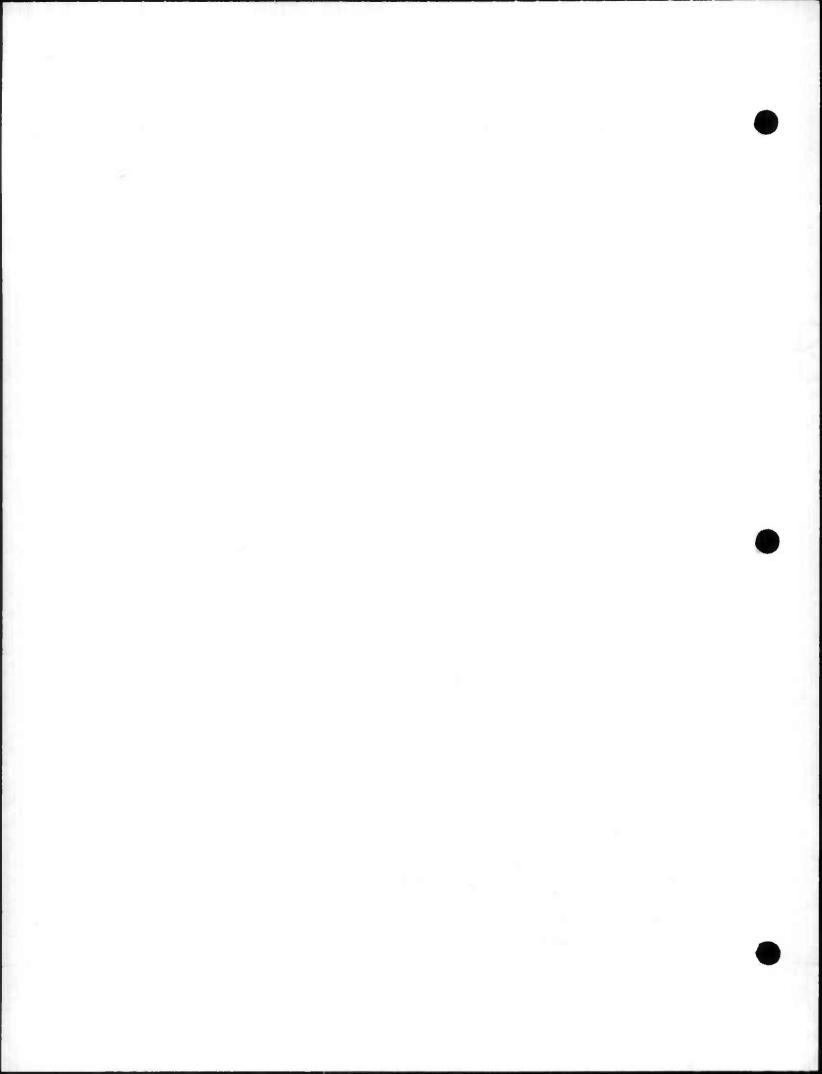
5 Pending

6 Could not be

determined

KOUW 1833 FOREST OR Annapolis.

Julia Dawdon Randall



		mt. Page
120	hysician	vurial-transit pe
BALTIMORE, MARYLAND 21215-0020	et hours after death. Page 6 may be retained by the hospital or attending physician	filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page no removal
YLAND	by the hospit	be detached
, MAR	be retained	ge 5 should
IMORE	Page 6 may	al director, pa
BALT	ifter death.	the funera
	4 hours	filled in by the

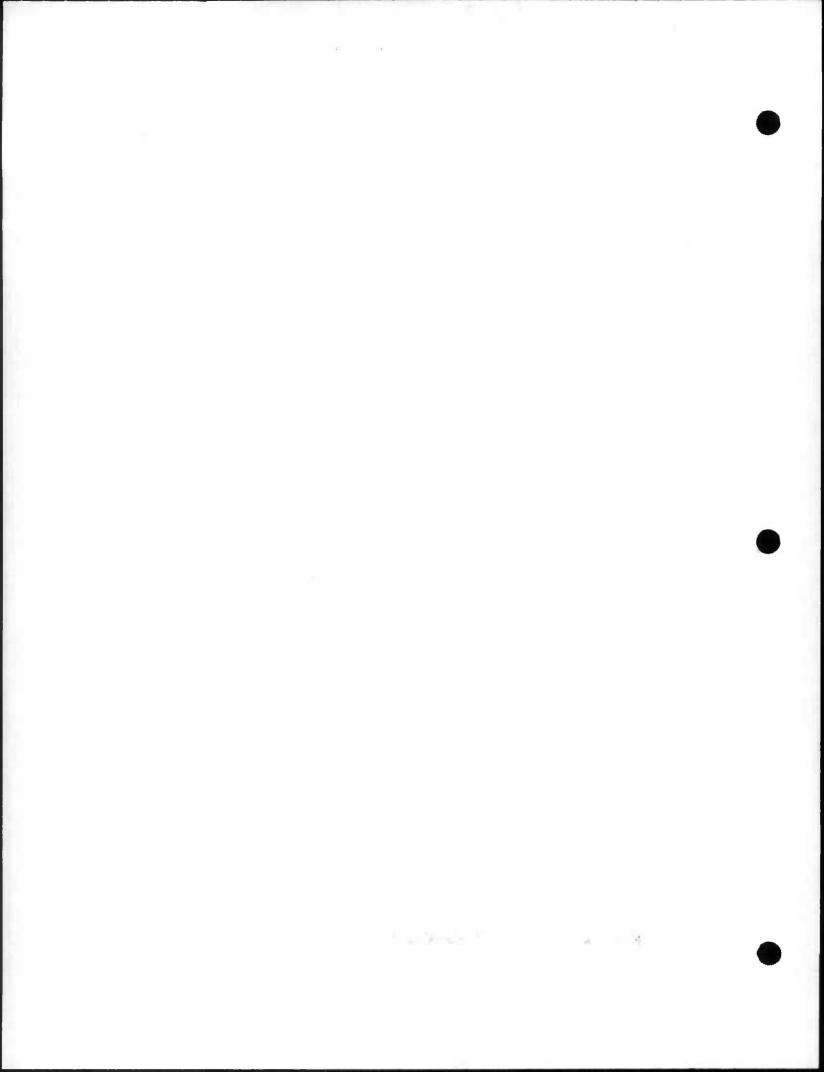
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR				EKIIF	ICALI	E OF	DEATH		REG. NO			
	1. DECEDENT'S NAME (First		atrick	CANIN	ON C	r.				e of DEATH TH D Tuary	AX	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUME		5. SEX	GANN 6. AGE (In yrs.		IF UNDER	1 VEAD	IF UNDER 24 HRS.	+	oruary OF BIRTH	2/,		4:00 A.M
	081-24-603	0	1 ₹ M 2 □ F	or ride (m yid.	63 ^{RS.}	MONTHS	DAYS	HOURS MIN.	(Mon	th, Day, Year)	1931	Country	PLACE (State or Foreign V) New York
~	9a. FACILITY NAME (If not in							OR LOCATION OF D				NTY OF D	
010	Franklin Sc RESIDENCE OF DEC	EDENT	ospital				ssvi				Balt	imor	e County
DIRE	Maryland	10b. COUNTY	Harford		10c. CIT	Y, TOWN (Bel Air					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL DIRECTOR	900 Jessi	cas Lan	е				10	7. ZIP CODE 21014			10g. CITI	ZEN OF W	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 X 3 Widowed 4 Divo	Merried	FORCES? 1 IF YES, GIVE W	EVER IN U.S. / TYPES 2 [THOR DATES CAN	ARMED NO	- 1	If yes, sp	CENOENT OF HISPA Hecity Cuban, Maxica 2 NO Special	en, Puerto	N? (Specify Yes Rican, etc.)	or No-	14. RACE Black Specifi	- American Indian, , White, atc. y: White
		EDENT'S EDUCA y highest grade co		1	DECEDENT'S (Give kind of	work done -	CCUPATION MICHAEL	ON ost of working	16	b. KIND OF BUS	SINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0	1-12)	College (1-4 or 5+		ffice	se retired.)				Oil	Compa	any	
ш	17. FATHER'S NAME (First, M John Jose		non					16. MOTHER'S NA Nell	ME (First,	Middle, Meiden UNK) L	Sumame) ynch		
TOB	190. INFORMANT'S NAME (7) Anne L. G				196. MAILING 900 Je	ADDRESS SSIC	S (Street &	ind Number or Rural Lane, Be	Aoute Nun	nber, City or Tow	n, State, Zip yland	Code)	.014
	20e. METHOO OF DISPOSITI	n 3 🗆 Remove	al from State	cemetery c	EAND OATE	ther placel			DA.		CATION —		
	21. SIGNATURE OF JUNERA		ISEE	1 mrdii	ATEM I	22.	NAME A	ND ADDRESS OF FA	CILITY				Maryland
	Stysly	n (1.1	Muzels			1	1317	Cokeshu	ry R	Oad A	hingo	lon	ome, P.A. Md 21009
		eart fallure, Lis	mplications that st only one caus	ceused the deep on anch in	death. Do r na.	not enter	the mo	de of dying, suc	h aa cer	diac or respi	ratory arr	est,	Approximata interval Batween
	iMMEDIATE CAUSE (Findisease or condition resulting in death)		Bowel P	erfora	tion.								Onset and Death 2 Days
	resulting in death)	8.,		OR AS A CONS		F):							2 Days
5	Sequentially list conditi	lons, b.	Metasta				lan!	oma.					4 Years
Ę	if any, laeding to immed cause. Enter UNDERLY!	NG	c. Small Bowel Obstruction.							10 0			
	CAUSE (Disease or inju that initiated events resulting in death) LAS	2	DUE TO (OR AS A CONS	EQUENCE OF	F):	l. a						12 Days
CERTIFICATION	readiting in death) LAS	d.											
DICAL	PART ii. Other significe	nt conditions	contributing to	death but not	resulting	in the un	deriyin	g cause given in	Part i.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
3										1 [] YES 2			COMPLETION OF CAUSE OF DEATH?
ž	DID TOPACCO III	SE CONTROL	DUTE TO CAL	ICE OF DE	4711 \		=	1					1 TES 2 NO
FILTSICIAN: M	25. WAS CASE REFERRED TO	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
2	EXAMINER? 1 YES 2 NO					OTHER		e 5 🗆 Residence	6 Oth	er (Specify)			
	27. MANNER OF DEATH	Pending	28e. DATE OF I (Month, De	NJURY y, Year)	26b. TIM		28c. INJ			SCRIBE HOW I	NJURY OCC	URED	
5	2 Accident	nvestigation	28a PLACE OF	IN HIDY As a		M		rES 2 NO					
	3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, building, stc. (Specify)					meat, rect	ory, onic		281. LOC	CATION (Street e or Town, Stete)	nd Number	or Rural Ro	oute Number,
COMPLE								end place, end due					end manner ee stated.
	296, SIGNATURE AND TITLE	OF CERTIFIER		1: ^				29c. LICENSE NUI					(Month, Day, Year)
	30. NAME AND ADDRESS OF	DEDSON MILE	OMBI ESSE	1-17	F44.07 (7	01.		D439	60		Fe	627	7, 1995
	Kadi Nabi	1, M.D.		Frankli			Dr.	Baltime	ore,	MD. 21	1237.		
	31. DATE FILED (Month, Day, 1)	Ž" 1995	32. AEGISTRAR	'S SIGNATURE	arball								
			<u> </u>										DHMH-16 Rev 1/89



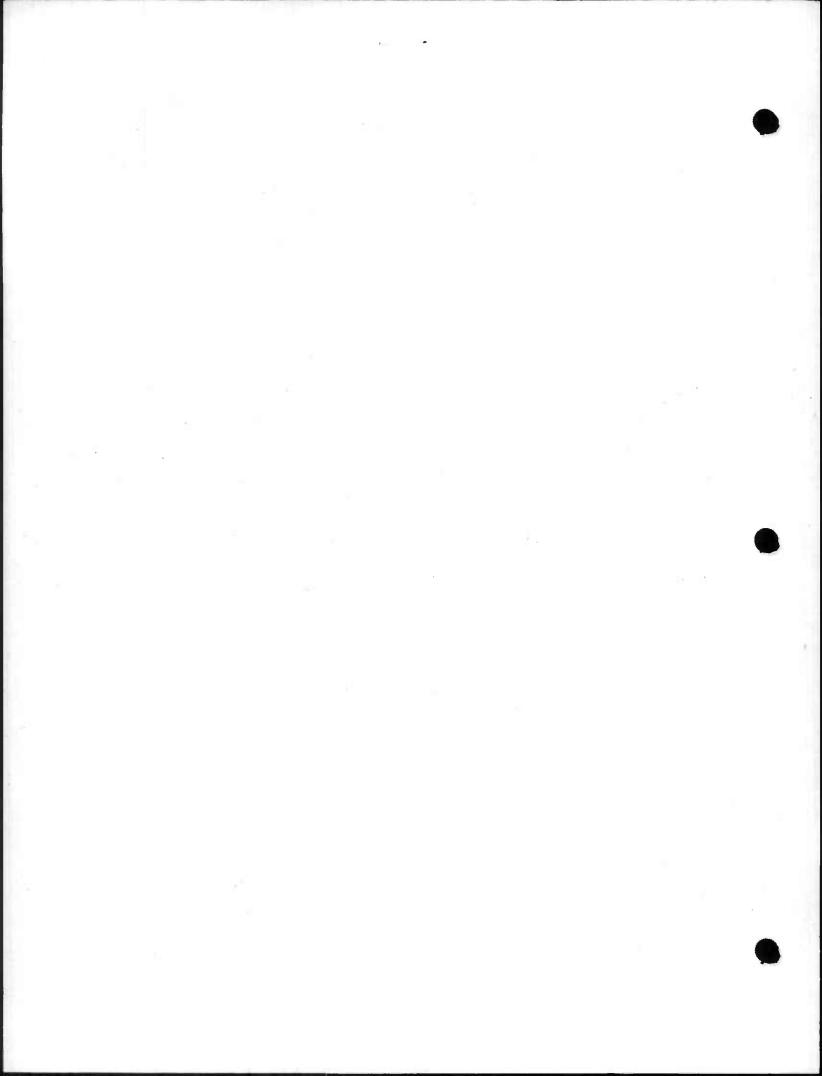
	/	2 Y	/
BALTIMORE, MARYLAND 21215-0020	the law requires that the death certificate be executed with nours after death. Page 6 may be retained by the hospital or attending physician.	e has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should to be bot. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pa be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remoral.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG NO.

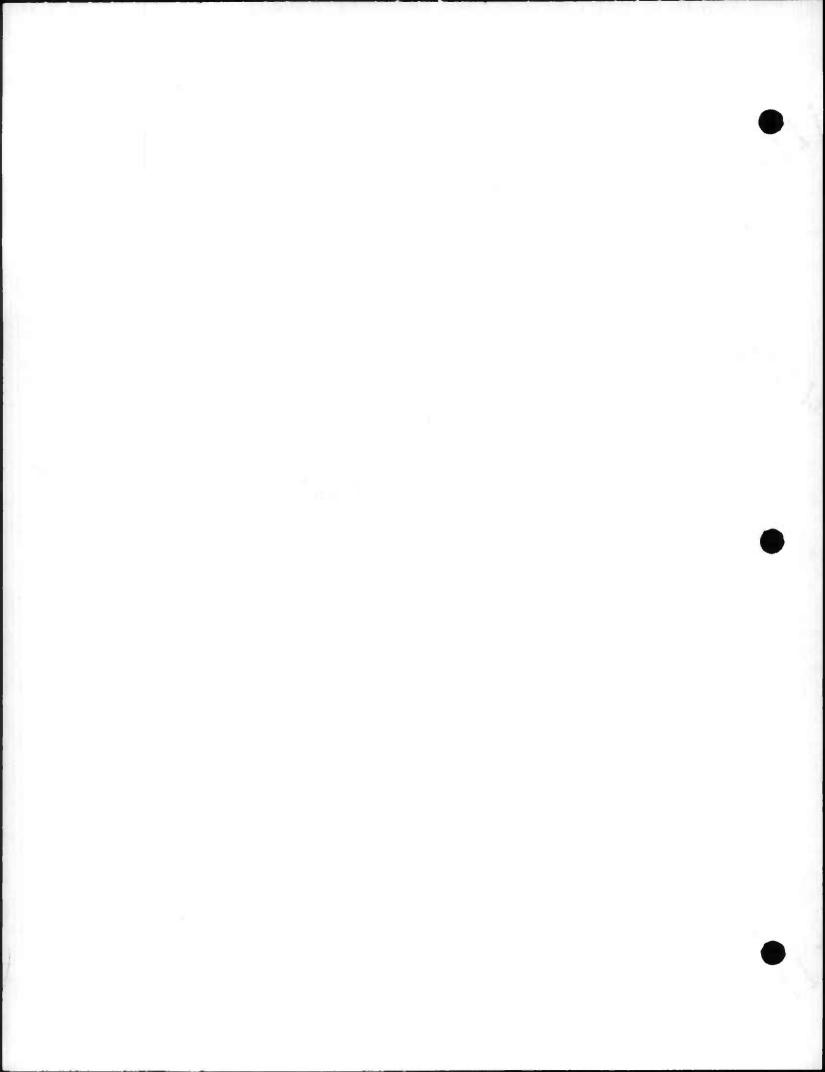
	1 - STATE REGISTRAR	CI	ERTIFI	CATE O	F DEATH	R	EG. NO.		
- 8	1. DECEDENT'S NAME (First, Middle, Last)			7		2. DATE OF D	DEATH		3. TIME OF DEATH
2	WALTER HENRY 6	JOETZE	, 3	B		P PRILA	HRY 27	1995	DIAT PM
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. las	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF B	ional /		IPLACE (State or Foreign
	219-05-7774 1X M 2 C	_ / 1	YRS.	MONTHS DAYS	HOURS MIN.	Aug. S	1920	Count	
	9a. FACILITY NAME (If not institution, give street and numb			9b. CITY, TOW	OR LOCATION OF DE	ATH		DUNTY OF D	EATH
DIRECTOR	Fallston General Ho	ospital			Fallsto	n		Hai	rford
Ä	10s. STATE 10s. COUNTY		10c. CITY,	TOWN OR LOC	ATION				10d. INSIDE CITY
	Maryland Harfo	ord			Joj	ppa			LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 822 Joppa Farm Road				101. ZIP CODE 2108!	5	10g. C	TIZEN OF	WHAT COUNTRY? USA
S.	500000	CEDENT EVER IN U.S. AR	MED		ECENDENT OF HISPAN			14. RAC	E — American Indian.
BY F	3 Widowed 4 Divorced	? 1 VES 2 1	10		specify Cuban, Maxica ES 2 X NO Specify		, atc.)	Spec	
	15. DECEDENT'S EDUCATION	WII	CEDENT'S U	SUAL OCCUPA	TION	16h KINI	D OF BUSINESS/	MDUSTRY	white
ETE	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(G	ive kind of wo Do NOT use	ork done during i retired.)	nost of working	Tob. Kill	D OF BOSINESS!	NDOSTAT	
COMPLETED	12		od Pat	ttern M	Maker	Ma	nufactu	rina	
ON	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA				
BE C	Walter Henry Goetze, S	Sr.			Elizabe	eth (nn	m) Schv	vab	
	19a. INFORMANT'S NAME (Type/Print)		b. MAILING A	ADDRESS (Stree	t end Number or Rural I				
5	Naomi R. Goetze	8:	22 Joi	opa Fai	m Road, i	Joppa.	Md. 21	.085	
	20a. METHOD OF DISPOSITION	20h BLACE	ANDDATEO	DISPOSITION		DATE	20c. LOCATION		wn, Stata
	1X Buriel 2 Cremation 3 □ Removal from Sta 4 □ Donation 5 Other (Specify)	Morel:			Park 3	/2/95	Parkwi l	le N	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	2 11		22. NAME	AND ADDRESS OF FA	CILITY			
þ	► MY9000000 . 1/1	MART			d K. McCo				
	23. PANT I. Enter the disease, or complication	ie thet caused the de	eth. Do no	t ofter the n	Cokeshury	ROAD,	Abingo or resolutory	ion N	1d 21009
	shock, or heart failure List only en	a ceuse on each line	le -	/	,				Interval Between
	IMMEDIATE CAUSE (Final disease or condition								Onset and Death
- 8	resulting in death)	UE TO FOR AS A CONSE	DUENCE DE	ave To	on				
_	- ACC ND								i I
ō	Sequentielly list conditions, If any, leading to immediate								
CERTIFICATION	cause. Enter UNDERLYING								. A.
Ĕ	that hittiated events	UE TO (OR AS A CONSE	QUENCE OF)	1					4 Y
F	resulting in deeth) LAST								
	PART II. Other significant conditions contribution	0.					and Charme	- 1	
DICAL	Access to the second	/ 7 /		the underly	ng cause given in	Part I. 24a.	PERFORMED?	246	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
	Chronic remai	111	ve	A	Carlo Cont		YES 2 NO		OF DEATH?
M	fosterion Ep	18 focks	5 4	ullh	aluemi	a			1 THE 2 NO
Z									
201	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITA	L: \ /	- 1	OTHER:	PLACE OF DEATH (CN	ock only one;			
2	1 ☐ YES 2 NO 1 ☐ Impetion	/	□ DOA	I C Nursing He	me 5 - Residence	6 🗆 Other /Spe	scify)		
YSIC	27. MANNER OF DEATH 38s. DA	ITE OF INJURY Onth, Day, Year)	INJU	RIY Y	NJURY AT YORK?	284. DESCRIB	E HOW INJURY O	DOCURED	
PHYSICIAN: MI	/Mc	1 Netural 5 Pending 2 Accident Investigation M 1 YES 2 NO							
BY PHYSIC	1 Natural 5 Pending 2 Accident Investigation	water many constraints. The same							
BY	1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide a Could not be	ACE OF INJURY — At he fiding, etc. (Specify)	mu, farm, atr	reet, factory, of	lce	28f. LOCATION City or Tox	W (Street and Mum en, State)	ber or Huraf I	Route Number
BY	1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide a Could not be determined	ACE OF INJURY — At he liding, etc. (Tipecity)	me, farm, str	wet, factory, of	ice	281, LOCATION City or flav	V (Street and Num en, State)	ber or Plumi i	Route Number
BY	1 Netural 5 Pending Investigation 2 Accident a Could not be determined 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the b	nest of my knowledge, de	ath occurred	l at the time, ds	ta and place, and dua	to the cause(s)	en, State) and menner as a	stated.	
BY	1 Netural 5 Pending Investigation 3 Suicide a Could not be detarmined	nest of my knowledge, de	ath occurred	l at the time, ds	ta and place, and dua	to the cause(s)	en, State) and menner as a	stated.	
COMPLETED BY	1 Netural 5 Pending Investigation 2 Accident a Could not be determined 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the b	nest of my knowledge, de	ath occurred	l at the time, ds	ta and place, and dua	to the cause(a)	and menner as a place, and due to	itsted,	
BE COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 4 Homicide a Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beat and a suicide AND TITLE OF CERTIFIER CERTIFIER AND TITLE OF CERTIFIER	pest of my knowledge, de ta of axamination and/or i	sth occurred investigation	I at the time, de	te and place, and dua death occured at the	to the cause(a)	and menner as a place, and due to	itsted,	i) and manner as stated.
COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 4 Homicide Check only one) 2 MEDICAL EXAMINER: On the beat	pest of my knowledge, de ta of axamination and/or i	sth occurred investigation,	I at the time, de	te and place, and due death occured at the	to the cause(a)	and menner as a place, and due to	atsted. the cause(s	i) and manner as stated. (Monthy Day, Year)
BE COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 4 Homicide a Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic suicide AND TITLE O CERTIFIER 38 NAME AND ADDRESS OF PERSON WHO COMPLETER	post of my knowledge, de is of examination and/or is cause of DEATH (ITE)	sth occurred investigation,	I at the time, de	te and place, and due death occured at the	to the cause(a)	and menner as a place, and due to	atsted. the cause(s	i) and manner as stated. (Monthy Day, Year)
BE COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 4 Homicide a Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic suicide AND TITLE O CERTIFIER 38 NAME AND ADDRESS OF PERSON WHO COMPLETER	pest of my knowledge, de ta of axamination and/or i	sth occurred investigation,	I at the time, de	te and place, and due death occured at the	to the cause(a)	and menner as a place, and due to	itsted,	i) and manner as stated. (Monthy Day, Year)



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	6 3	has	Dep	1 23
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH	AND	MENTAL	HYGIENE
CERTIFICATE OF DEAT	H		DEC NO

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC	MENT OF I	EALTH AND	MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF DEA	TH
	FRANK	Н.		GAL	IPO	FEB			95	6:45	Аи
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH		, BIRTH	PLACE (State or F	
	577-09-7220	1 🖾 M 2 🗌 F	80 YRS.	IONTHS DAYS	HOURS MIN.	Jan.	25,	1915 N	Count lew	" Jersey	
_	9e. FACILITY NAME (If not institution, give	street and number)		DE. CITY, TOWN	OR LOCATION OF D	DEATH		9c. COUNT			
DIRECTOR	UNIVERSITY S.T	r.u.		Baltim	ore Ci	ty					
	10a. STATE 10b. COUNT		10c. CITY,	TOWH OR LOCA	TION					10d. INSIDE CIT	Y
		e Georges	Lanh	am						1 X YES 2	NO
₹	10a. STREET AND NUMBER			10	. ZIP CODE			10g. CITIZE	N OF V	VHAT COUNTRY?	
剪	6221 93rd Avenu	е			20706			USA	A		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 2 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexic 2 12 NO Spec	en, Puerto I	i? (Specify Yes Rican, etc.)	or No- 1	4. RACI Black Speci	— American ind k, White, atc.	len,
		I WW II		1					7.00	White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	ICATION a completed)	16a. DECEDENT'S US (Give kind of wor	rk done during mo		16b	KIND OF BUS	SINESS/INDUS	STRY		
ا لاِ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)		- 1					
Σ	12	0	Agent					urance	2		
	17. FATHER'S NAME (First, Middle, Last) Joseph Galipo				16. MOTHER'S N			Sumame)			
H					Unobta						
2	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural					06	
٦	Kathleen Baccala		6221 9	3rd Ave	enue, La	nham,	Mary.	Land	207	06	
	20s. METHOD OF DISPOSITION 1 ← Burtel 2 □ Cremation 3 □ Man	novel from State con	PLACE AND DATE OF	DISPOSITION (Na	ame of	DAT		CATION — CH			
1	4 Denation 5 Other (Specify)		ort Lincol			3/1	/ Brer	twood	, M	aryland	
- 1	22. NAME AND ADDRESS OF FACILITY Hines—Rinaldi Funeral Home 11800 New Hampshire Avenue										
	1/01 V 7.1	14100			er Sprin				00/		
	23. PART I. Enter the diseases, or ahock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Liet only one ceuse on e. NECK TIMUY DUE TO (OR AS A	ach iine.				liec or reapi	ratory arres	it,	Approxim interval 8 Onset and	etween
	Tourising in deathy	DUE TO (OR AS A	CONSEQUENCE OF):		79-110-3					+	
z	Secure Maller Het en addates	b									
	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	Cause. Enter UNDERLYING CAUSE (Disease or Injury	с									
	that initieted events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
ا ا		d									
AL O	PART ii. Other eignificant condition	ne contributing to deeth b	ut not reaulting in	the underlying	g cause given in	Part i.	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY F	INDINGS
	CARCINOMA DEL	NAG					PERFOR	WLD I		AMILABLE PRIOR	TO
HYSICIAN: MEDIC						_				OF DEATH?	
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	ПИОГ	UNCERTAI		TOSP	SUTON	1	1 YES 2	NO
₹	25. WAS CASE REFERRED TO MEDICAL	T	26. PLACE OF DEATH		OTTERNA	14 12					
	EXAMINER? 1XIX ES 2 NO	HOSPITAL: 1 Xinpetient 2 ER/Outp		THER:	e 5 🗆 Residence	4 C 0th					
Ē	27. MANNER OF DEATH	26a. DATE OF INJURY	26b, TIME (OF 28c, INJ		_	CRIBE HOW II	NJURY OCCU	BED	overt	1.000
7	1 Natural 5 Pending	2 23 Q	1270 I		RK?					TWHTH	
R	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	- At home, farm, stre			+	ATION (Street a				
	4 Homicide 6 Could not be determined	Pospusy	cify)	, , ,		City	or Town, State)			ops M	\cap
9 1	29a, CERTIFIER							_	_	Oles F.	
<u> </u>	(Check only	ICIAN: To the best of my knowl									
COMPLEIED		ER: On the besis of examination	n and/or investigation,	in my opinion, d	eath occured at the	e time, date	and place, an	d due to the o	ceuse(s	end menner as s	tsted.
N L	IGNATURE AND TITLE OF CERTIFIE	1 .0 .			29c. LICENSE NU	MBER		29d. DATE S	IGNED	(Month, Day, Year)	
5	mullime me	nell			O.C.	M.E.		FE	B 2	7,1995	
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE				-					
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	REU M.	111 Pe	nn Str	eet, B	alti	more,	Mar	yla	and 212	01
	MAR 03 1995	32. REGISTRAR'S SIGN	AT LA					-			

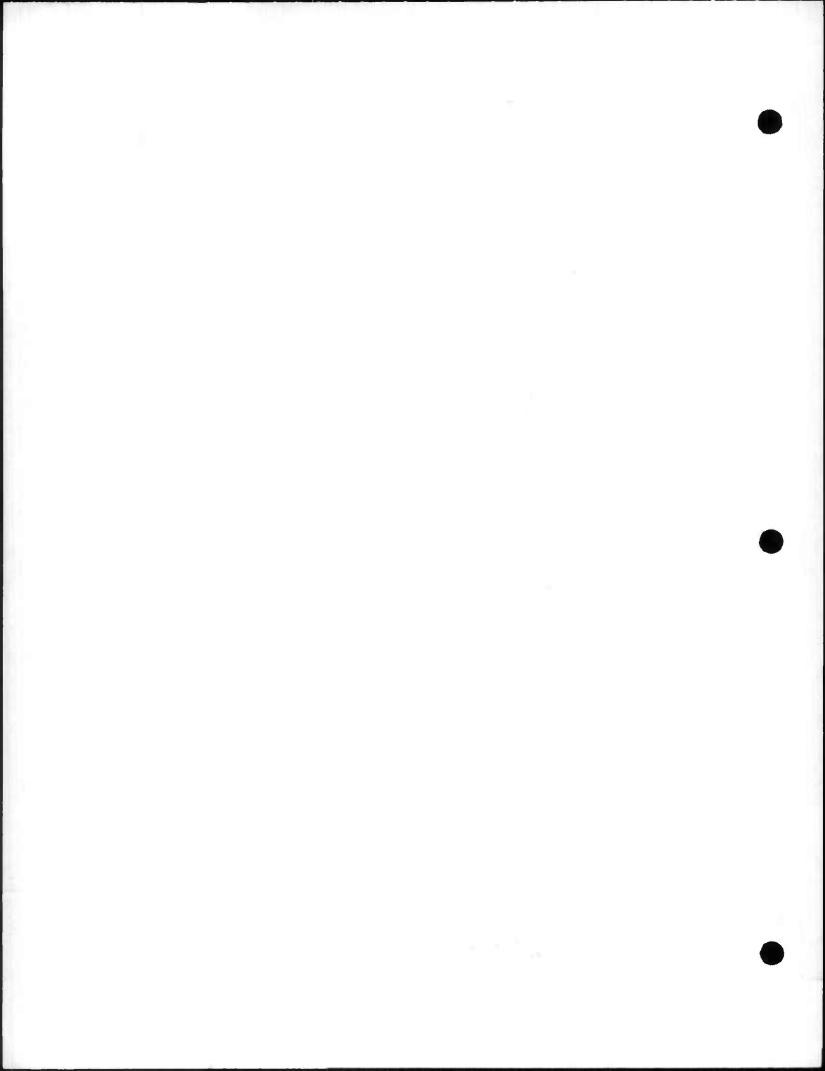


BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Jaw Imputes that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit pages 1.2 servand
be filed within 72 hours after death with the State Dept. or Hearth and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFICA			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Martha	I.	(-	allma	nel	February	27 1995	+ MP "
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign
	217-46-6188	1 🗆 M 2 🗀 F	86 YRS.	THE DAYS	HOURS MIN.	February 2	2, Wash	nington, D.C.
æ	9e. FACILITY NAME (If not institution, give str		9b.		LOCATION OF DE	ATH	9c. COUNTY OF	
DIRECTOR	Shady Grove Advent	tist Hospital		Roo	ckville		Montgo	omery
REC	10e. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATIO	ON			10d. INSIDE CITY
	Maryland Mont	gomery	Gait	hersbu	rg			LIMITS? 1 X YES 2 □ NO
3AL	10e. STREET AND NUMBER			101, 2	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	20222 Gentle Way				20879		U.S.A	Α.
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U FORCES? 1 YES	2 1 NO			IC ORIGIN? (Specify Yee n, Puerto Rican, etc.)	or No— 14. RAC Blac	E — Americen Indian, ck, White, etc.
B	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATE	ES	1 🗌 YES 2	NO Specify	•	Spe- Whi	
ED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION 1	6s. DECEDENT'S USU	AL OCCUPATION	1.	16b. KIND OF BUS		rce
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use ret	done during most lired.)	or working			
MP		1	Homemak	er		Own H	lome	
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Melden	Surname)	
BE	Anders R. Lofsti	cand				. Johnson		
5	Marjorie Ann Pease					Noute Number, City or Town		1 21610
	20a. METHOD OF DISPOSITION	20h PI	LACEAND DATE OF DI			ve Cheste	CATION - City or T	
	1 Buriel 2 K Cremetion 3 Remo	rval from State cemete	ery, cremetory or other propolitan	olace)		1		
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE /		22. NAME AND	ADDRESS OF FAC	/1/95 Alex		
151	1/5 about 1					lins Funer		
	23. PART i. Enter the diseases, or cr	omplications that caused to	he death. Do not a	500 Uni	Lversity	Blvd.,W.	Sil.Spr.	
	anock, or heart fellure. L	iat only one ceuse on each	h line.	miler the mode	e or dying, such	as cardiec or reepi	ratory arrest,	Approximata interval Batween
	iMMEDIATE CAUSE (Final disease or condition	acuti	CINOI	12 5 10	.011	12,00	00-10-	Onast and Death
	resulting in death) a	DUE TO (OR AS A CO	ONSEQUENCE OF):	Urba	1000	la ac	ecau	4 3444
z	- Thaley agest the butering days							
일	Sequentially list conditions, DUE TO (OR.AS*A CONSEQUENCE OF):							
	If eny, leading to immediate cause. Enter UNDERLYING							/
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	whe	te, ou	ulli	tu			
TIFICA	cause. Enter UNDERLYING	DUE TO (OR AS A CO	ONSEQUENCE OF):	ulli	the			
CERTIFICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	whe	DNSEQUENCE OF):	uli	tu			
AL CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO		e underlying	ceuse given in F			D. WERE AUTOPSY FINDINGS
AL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO		e underlying	ceuse given in F	Part i. 24a. WAS AN PERFOR	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE
AL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other algnificent conditions	DUE TO (OR AS A CO	not resulting in th		ceuse given in F	PERFOR	MED?	AWAILABLE PRIOR TO
AL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR	DUE TO (OR AS A CO	not resulting in th	□ NO 🗹	ceuse given in F	1 TYES 2	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS A CO	DEATH YES [PLACE OF DEATH (C	heck only one) HER: Nursing Home 28c. INJUR	UNCERTAIN 5 - Residence (1974 AT 1977)	PERFOR	MED? □ NO	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation	DUE TO (OR AS A CO	DEATH YES [PLACE OF DEATH (C PINT 3 ODA 4 OT 18JURY	heck only one) HER: Nursing Home 28c. INJUE WORK 1 YE	UNCERTAIN 5	PERFOR 1 YES 2 5 Other (Specify) 28d. DESCRIBE HOW IN	MED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending	DUE TO (OR AS A CO	DEATH YES PLACE OF DEATH (Cont 3 DODA 4 DEATH (INJURY) At home, ferm, street	heck only one) HER: Nursing Home 28c. INJUE WORK 1 YE	UNCERTAIN 5	PERFOR 1 YES 2	MED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 296. CRTIFIER (Check only one) 2 MEDICAL EXAMINER 295. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS A CO	DEATH YES DEATH (COMPANDED TO THE STREET OF DEATH (COMPANDED TO THE STREET OF THE STRE	NO Deck only one) HER: Nuraing Home 28c. INJUI M 1 YE , tectory, office the time, date er my opinion, des	UNCERTAIN S Residence of the triple of the triple of the triple of the triple of the triple of the triple of triple	PERFOR 1 YES 2 5 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street e. City or Town, Strate) to the cause(e) end menitime, date end place, end	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

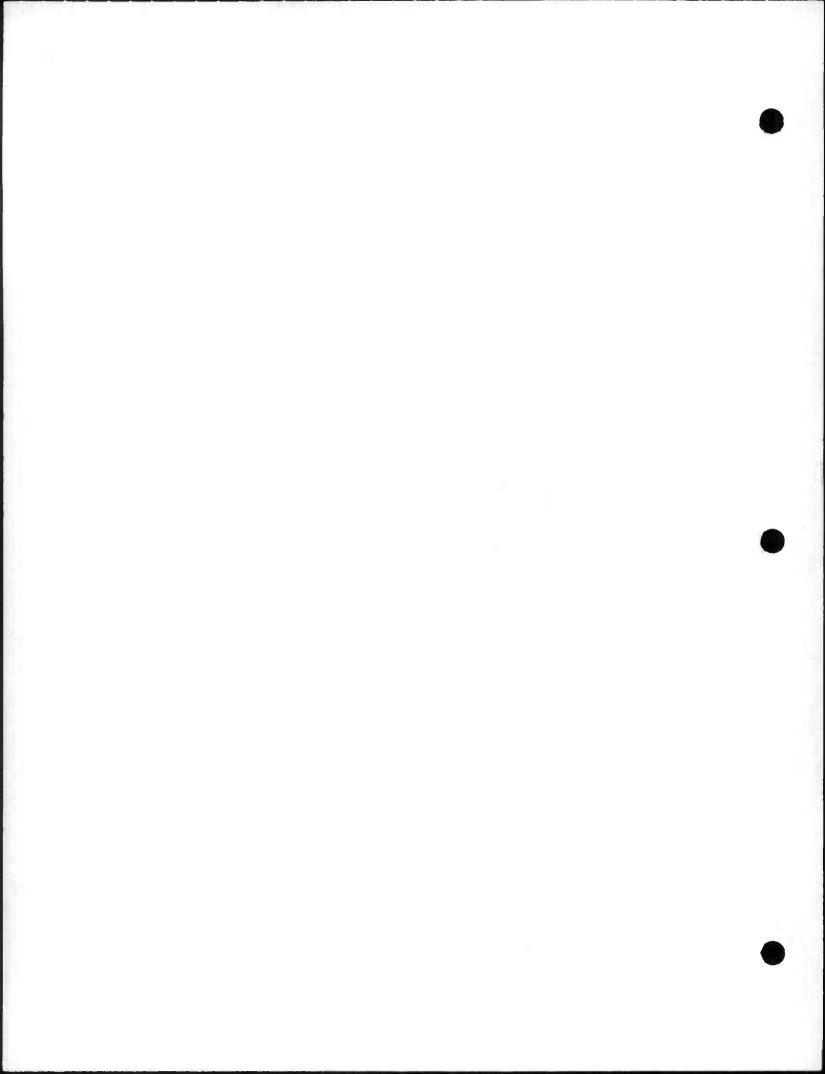
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH /	AND MENTAL HYGIENS
CERTIFICATE OF DEAT	H REG NO

	1 - STATE REGISTRAR	STATE OF MARYL	AND /	DEPAR	TMENT	OF HE	EALTH AND DEATH	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) Mars	garet R.		Garb				MON	E OF DEATH		YEAR	3. TIME OF DEATH 12:05 P
	4. SOCIAL SECURITY NUMBER		(In yrs. last	birthday)	IF UNDER 1	YEAR	IF UNDER 24 HRS.	_	.22, 1	995	a BIRTH	PLACE (State or Foreign
	578 05 9575	1 🗆 M 2 🖔 F	32	YRS.	MONTHS	DAYS	HOURS MIN.	Jan	". PT, "19	13	West	Virginia
e	90. FACILITY NAME (If not institution, give to Carriage Hill I					town on	LOCATION OF D	EATH		9c. COUN		
5	RESIDENCE OF DECEDENT	Jethesua			De	etile:				MOI	rego	mery
E I	10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN OF	R LOCATIO	ON			-		10d. INSIDE CITY
		gomery		Bet	hesd	а					1	LIMITS?
₹ 	10e. STREET AND NUMBER						ZIP CODE			10g. CITIZ	EN OF W	HAT COUNTRY?
FUNERAL DIRECTOR	5215 Cedar Lane						20814			U	.S.A	
	11. MARITAL STATUS 1 X Never Married 2 Merried	12. WAS DECEDENT EVER II FORCES? 1 YES	2 XN	MED O	11	yes, spec	NDENT OF HISPA			or No-	Black	- American Indien, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		1	YES 2	NO Speci	fy:			Specif	y: White
ED	15. DECEDENT'S EDU (Specify only highest grade	JCATION COMPLETE	16a. DE0	CEDENT'S	USUAL OC	CUPATION		16	b. KIND OF BUS	INESS/INDU		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	vork done du le retired.)	uning most	or working					
COMPLETED		+3	Eco	onom	ist			F	edera1	Rese	rve	Board
ဗ	17. FATHER'S NAME (First, Middle, Last)						18. MOTNER'S N			Surneme)		
BE	Robert Garber 190. INFORMANT'S NAME (Type/Print)								tchie			
2	Robert Garber						Number or Aural				Code)	
	200. METHOD OF DISPOSITION	201	-		FDISPOSIT					CATION — C	ih. as Ta-	
	1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	loval from State	ation	natory or a	lem.	Park			7 Fall	s Chu	rch,	Va.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. N	AME AND	ADDRESS OF FA					
	1 Lung	Semin	-m	1	513	30 W	I AVE N	W WA	SHINGTO	ON DC	200	16
	23. PART t. Enter the diseases, of	complications that caused List only one cause on a	d tha dea	ath. Do n	ot enter t	he mode	a of dylng, suc	ch as car	diac or respi	ratory arre	st,	Approximate
	IMMEDIATE CAUSE (Final	ciet only one cause on a	avii iiiia.									Onset and Deat
	disease or condition resulting in death)	Pneumon										2 weeks
		Oue to (or as a			,							W
NO	Sequentially list conditions,	Cerebro DUE TO (OR AS A				Laeni	LS					Years
TA	if any, leading to immediata cause. Enter UNDERLYING	Atheros				2256-	-genera	lize	1			Years
FE	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A				-400	Schola		-			Tears
CERTIFICATION	resulting in death) LAST	d										
	PART II. Other significant condition	ns contributing to death h	ut not re	eulting I	n the und	lacivino (cause alven in	Dart t	24s. WAS AN	Umanay	Lan	
CAL		- continuing to down b	or not re	autung i	ii tile tilla	ettynig	cause given in	Part L	PERFOR		246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC		· · · · · · · · · · · · · · · · · · ·							1 TYES 2	□ №	_	OF DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	E DEAT	TH YE	ςΠи	0 411	LINCEDTAL	M []				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				N (Check on	4545	ONCERNA					
Sic	1 YES 2 ANO	HOSPITAL: 1 Inpetient 2 ER/Outp	atlent 3	□ DOA	OTHER:	na Home	5 Residence	6 □ Oth	er (Specify)			
Ě	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		28b. TIMI	OF 2	8c. INJUR	RY AT		SCRIBE HOW IN	JURY OCCL	RED	
ВУ	14 Natural 5 Pending 2 Accident Investigation	(MONIII, Day, Year)		INJ	M	1 YE	S 2 NO					
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At hon	ne, farm, a	treat, lector	ry, office		281. LOC City	ATION (Street e. or Town, State)	nd Number o	r Aurel Ad	oute Number,
COMPLETED	29e. CERTIFIER XXCERTIEVING BAYE	ICIANI To the best of an in-						1				
MP	(Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my knowl ER: On the bacle of examination	ledge, dea n end/or in	th occurre	d at the tim	inion des	nd place, end due	to the ca	use(e) end men	ner as atated	d,	
	29b. SIGNATURE AND TITLE OF CERTIFIE				.,y opi				one prece, and			24//
B	Brent A B	LOOL MO				12	D378	40	Ì			'Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WH Brent A. Berger	O COMPLETED CAUSE OF DEA	ATN (ITEM	27) (Type,	Print)	lke i	#103 Ro	ckvi.	11e Má			,1995 3179
1					TE 1.	LRE 1	103 00	CKVI.	LIE, MC	. 200	,,,,,	J117
	FEB 28 1995	JULY DEGISTRAR'S'SIGN	rhand	all								



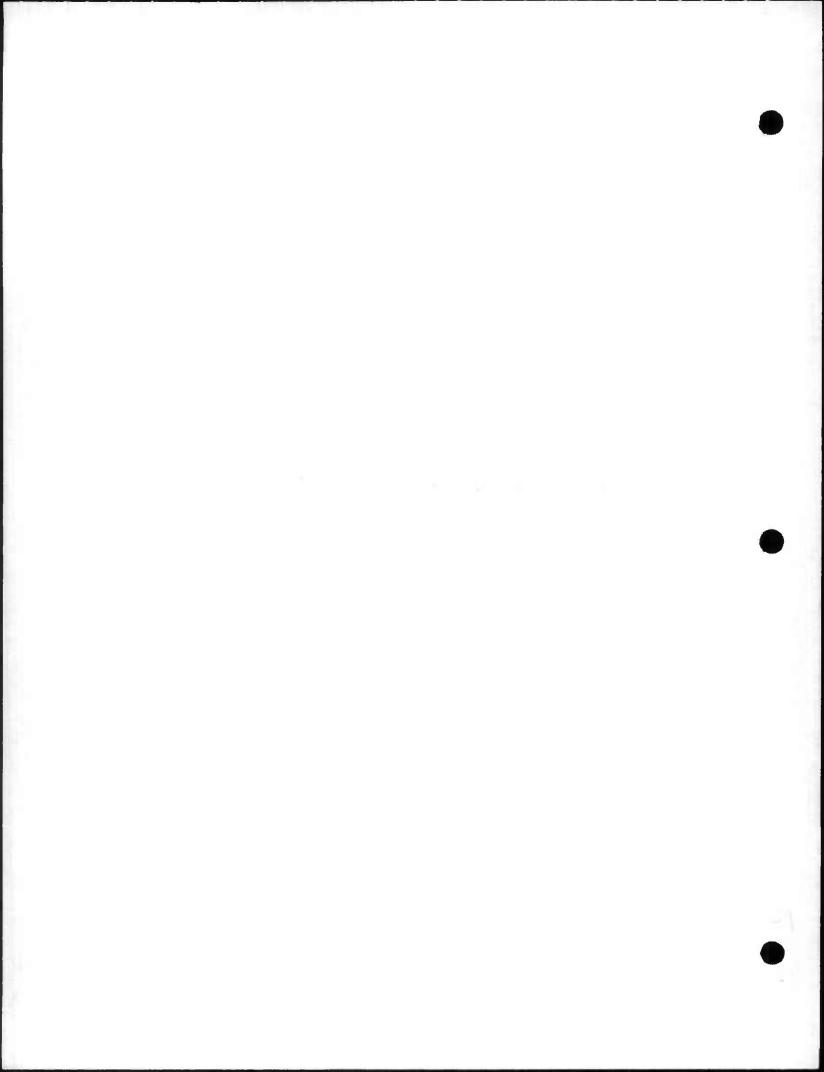


BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate has been upone by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death can be seen upone by the completely fined in by the function page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Upopt, of Ham 23 should be after the seen within the seen the seen the seen the seen that the seen the seen that the seen that the seen that the seen that the seen the seen that th
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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CALE	F DEATH	REG. NO	D.	
1 2	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	DODOTHY		I ADDEN				DAY YEAR	
	4. SOCIAL SECURITY NUMBER		LADDEN			02 2		4:15PM M
1 3	The second secon		(In yrs. last birthday)	IF UNDER 1 YEA		44	8. BIR	THPLACE (State or Foreign intry)
	577 24 8546	1 M 2 T F	70 YRS.	MONTHS DAY	B HOURS MIN	April 7,		.,
	9a. FACILITY NAME (If not institution, give street	et and number)		9h CITY TOW	N OR LOCATION OF		9c. COUNTY OF	ımter,S.C.
CC	Prince George Hos	pital Cente	r		Cheverly	DEATH	Prince	George's
DIRECTOR					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		TITMEC	dedige 3
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY							
1 22	TOB. STATE		tec. CITY	, TOWN OR LO	CATION			tod. INSIDE CITY LIMITS?
ā	Maryland Princ	e George's		Forest	7111e			1 XYES 2 NO
1	10e. STREET AND NUMBER			T	tor, ZIP CODE		I to- CITIZEN OF	WHAT COUNTRY?
2	1011 01 1 01	-			TO DELCE SCHOOL		TOG. CITIZEN OF	WHAT COUNTRY?
FUNERAL	1211 Shady Glen				20747		Unite	d States
15		2. WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED	13, WAS [ECENDENT OF HIS	PANIC ORIGIN? (Specify Ye	a or No- 14. RA	CE — American Indian,
	t Never Married 2 Married	IF YES, OIVE WAR OR E	ATES		ES 2 NO Spe	Ican, Puerto Rican, etc.)		ock, White, atc.
₽	3 XWidowed 4 Divorced				and the special specia		3,0	Black
	15. DECEDENT'S EDUCAT	TION	16a. DECEDENT'S 1	ISUAL OCCUP	TION	185 KIND OF BU	ISINESS/INDUSTRY	
E	(Specify only highest grade co		(Give kind of w	ork done during	most of working	TOOL KIND OF BU	SINESS/MDUSTRY	
1 5		College (1-4 or 5+)	P	roprie	or	Tet	Cleaners	
s ₹	8			- opiic.		000	orcancis	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	NAME (First, Middle, Maider	Sumame)	
	Thomas J.	Williams				Emma Ben	jamin	
BE	t9s. INFORMANT'S NAME (Type/Print)							
2	Lonnie Gladden		1211 SI	nady C	and Number or Rur	el Route Number, City or Tov Forestvill	vn, State, Zip Code)	and 20747
,			TETT DI	lady 0.	ch bi.,	TOTESCVIII	e, maryr.	and 20/4/
	20a. METHOD OF DISPOSITION	201	PLACE AND DATEO	FDISPOSITION	(Name of	DATE 20c. LC	CATION — City or	Town, Stats
	15 Burlel 2 Cremetion 3 Remove 4 Donation 8 Other (Specify)		edar Hil	er place)		3/1/95 St	المسالمة.	Manual 1
1	21. SIGNATURE OF FUHERAY SERVICE LICEN	ISEE /	edar IIII.		AND ADDRESS OF		urtrand,	Maryland
	JANIX	BUI	01			eral Servi	co Inc	
	18the Deci	E 7/0	11					n a aaaaa
	23. PART I. Enter the disesses, or con	mallostions that saves	W Company	1/400	Georgia	Ave., N.W.,	washingt	on, D.C. 20012
	shock, or heart fallure. Lis	it only one ceuse on e	ach line.	ot enter the i	node of dying, s	uch as cardiac or resp	iratory arrest,	Approximate Interval Between
1	IMMEDIATE CAUSE (Final	0			•			Onset end Death
-	disease or condition	Hans	1 to	1 on	10			1 11
	resulting in death)	DUE TO (OR AS	CONSEQUENCE					Mon
		muse	1.1.			lin . e. in	4.	1/40
CERTIFICATION	Sequentially list conditions, b	7 17 20 100	CONSEQUENCE OF		wid 1	my sloud 1	Craphi	MA 7 -
I E	If any, leading to immediate	DUE TO (OR AS)	CONSEQUENCE OF		7 -	,		
0	CAUSE (Disease or Injury	ongest.	ve Hz	ar -	Jacken	-		1921
<u>=</u>	that initiated events	DUE TO (OR AS	CONSEQUENCE OF	:	0			
E	resulting in death) LAST	Coron	u 4	in-	the			
8 8					7			
1	PART II. Other significant conditions of	contributing to deeth b	ut not resulting in	the underly	Ing ceuse given	n Part I. 24e. WAS AN		b. WERE AUTOPSY FINDINGS
DICAL	April 2 The rois	l unin	Fille.		Hemp.	PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	(-1/10)	- /-		-1-	1012	TIMES 1	NO	OF DEATH?
2	Un WillEbrand of							I YES 2 NO
ż	DID TOBACCO USE CONTRIE	BUTE TO CAUSE C	F DEATH YES	ON D	UNCERTA	IN 🗆		
≤	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH	(Check only or	e)			
PHYSICIAN:		IOSPITAL:		OTHER:		-1751		
≥	27. MANNES OF DEATH					8 Other (Specify)		
4		(Month, Day, Year)	28b. TIME INJU		NJURY AT VORK?	28d. DEŞCRIBE HOW	NJURY OCCURED	
₽	Netural 5 Pending Investigation			M 1 [YES 2 NO			
	3 Suicide 6 Could not be	28s. PLACE OF INJURY	- At home, term, at	reet, factory, of	fica	28t. LOCATION (Street	and Number or Rural	Route Number.
E I	4 🗍 Hamicide determined	building, atc. (Spec	ury)			City or Town, State)		92001711111
COMPLETED	29a, CERTIFIER							
집	(Check only	N: To the best of my know	ledge, death occurred	at the time, de	ite and place, and d	us to the cause(s) and me	nner sa stated.	
8	2 MEDICAL EXAMINER:							(a) and menner as stated.
ŭ								
BE	296. SIGNATURE AND TITLE OF GERTIFIER		an	tenting	29c. LICENSE N	UMBER	29d. DATE SIGNE	D (Month, Day, Year)
	rount kun	Lman	, My	/	Dost	74	1 2/2	4/95
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE				/		
	6510 Va -		River		4 1	1 207	377	
	31. DATE FILED (Month, Day, Year)			- a he	ma	/-	,	
	O O A O O	Jalia Davelson	P. J.					
	FFR 20 1995	Julia a municipa	nandally					
	1 100	,						DHMH-18 Rev 1/89



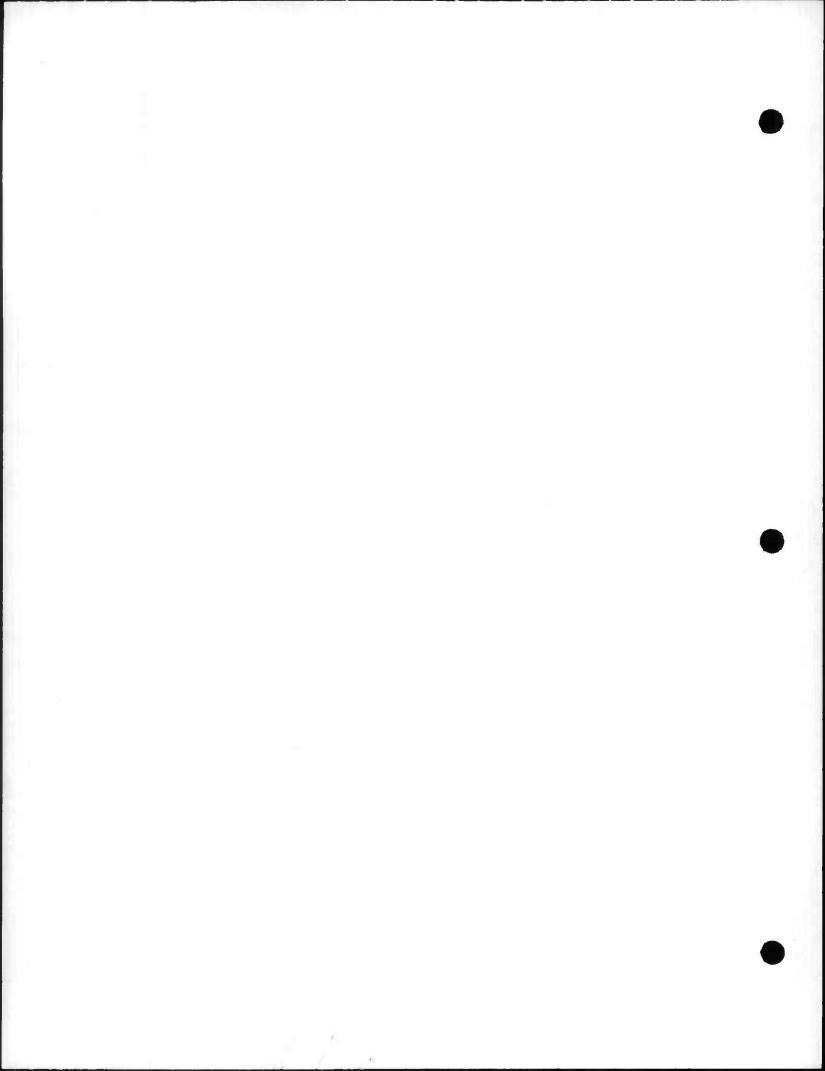
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEP	ARTMENT	OF HEALTH AN	ID MEI	NTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2.	DATE OF DEATH		3.	TIME OF DEATH
	Dorothy Tyler	Gray					-	AY 23, 19	YEAR 95	1:45 A M
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthde	y) IF UNDER	1 YEAR IF UNDER 24 HI	RS. 7. 1	DATE OF BIRTH (Month, Day, Year)			CE (State or Foreign
	202-34-7213	1 🗆 M 2 💢 F	51 YRS		DAYS HOURS MA		an. 15,	1944 1		ork
œ	9e. FACILITY NAME (If not institution, give s				TOWN OR LOCATION O				Y OF DEAT	
DIRECTOR	1504 Lemontree La	1e		511	ver Spring	g 		Montg	gomer	У
EC	10a. STATE 10b. COUNT	Y	10c. (CITY, TOWN C	R LOCATION				104	1. INSIDE CITY
DIF	Maryland Prince	ce George's	G	reenbe	1t					LIMITS?
AL	10e. STREET AND NUMBER				101. ZIP CODE			10g. CITIZE		COUNTRY?
LER	1 C Research Road				20770			Unite	ed St.	ates
FUNERAL	11. MARITAL STATUS 1 Never Married 2 XMarried	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13.	MAS DECENDENT OF HIS f yes, specify Cuben, Me	SPANIC O	RIGIN? (Specify Yes	or No 1	4. RACE — Black, W	American Indien,
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR			TYES 2 XNO S		rento riican, atc.)		Specify:	
	15. DECEDENT'S EDU	CATION	16a. DECEDENT	r's Hellal O	YCHRATION		16b. KIND OF BU	1		White
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind	of work done of use retired.)	furing most of working		160. KIND OF BU	SINESS/INDU	STRY	
P	, (0,12)	5-1-	Homes	naker			Own Ho	me		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	S NAME (First, Middle, Maiden			
BE (George T	yler			Dorot	thy		Ty1e	er	
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILI	NG ADDRESS	(Street and Number or Re	ural Route	Number, City or Tow	n, State, Zip C	ode)	
	James Henry Gray				h Rd., Gre	eenb	elt, Mar	yland	207	70
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem	oval from State	b. PLACEAND DATE	r other place!		1		CATION — CI		
	4 Donation S DOTHER (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	Fuler	ort Lin	coln (rematory 2	2/23	/95 Bre	ntwood	i, Ma	ryland
	1/1/6	11.			nes-Rinalo			ome, l	1800	
_	1/lef (-)	ene		Ne	w Hampshi	re A	ve. Sil	ver Sr	orine	, Md 20904
	23. PART i. Enter the diseases, or cahock, or heart failure.	complications that cause List only one cause on	ed the deeth. Do each line.	not enter	the mode of dying,	auch aa	cardiac or respi	ratory arres	it,	Approximata interval Between
	iMMEDIATE CAUSE (Finel disease or condition	1			0					Onset and Death
	resulting in death)	LUNG	A CONSEQUENCE	NW	CER					8mo's
_	_	OUE TO (OR AS	A CONSEQUENCE	OF):						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE	OF):						
CA	ceuse. Enter UNDERLYING CAUSE (Disease or injury	C								
E	that initieted events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE	OF):						
H	resulting in death) Exist	s								
	PART ii. Other significent condition	e contributing to death	but not resultin	g in the un	derlying ceuse given	in Part			24b. WEI	RE AUTOPSY FINDINGS
SC							PERFOR		COR	ILABLE PRIOR TO APLETION OF CAUSE
ME							1	4260		DEATH? YES 2 KNO
ä	DID TOBACCO USE CONTR	RIBUTE TO CAUSE (OF DEATH	YES 🗆 N	IO DU UNCERT	AIN [, , , , ,
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DI	_						
YSI	1 TES 2 NO	1 Inpetient 2 ER/Out		4 Nurs	: Ing Home 5 Residen	ce 8 🗆	Other (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)		IME OF NJURY	28c. INJURY AT WORK?	28d	DESCRIBE HOW II	NJURY OCCU	REO	
B	Accident Investigation	28e. PLACE OF INJUR	M 44 ham 4	M	1 YES 2 NO					
	3 Suicide 8 Could not be determined	building, etc. (Spe	ecify)	i, atteut, lacto	ry, office	281.	City or Town, State)	nd Number or	Rural Route	Number,
COMPLETED	290. CERTIFIER CERTIFYING PHYSIC	Class. To the heat of a 1								
₽ I	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my known. R: On the basis of examination	wiedge, death occu on end/or investiga	fred at the th	ne, date end place, end	due to the	e cause(e) end man	ner ee stated.		
	29b. SIGNATURE AND TITLE OF GUILLINGER	5					date and place, and			
H	Daniel R	sently	n	10	DC C	NUMBER	11			nth, Day, Year) - 95
임	30. NAME AND ADDRESS OF PERSON VINC	COMPLETEO CAUSE OF D	EATH (ITEM 27) (7/	pe, Print)	7		00		-23	- 73
	DANIEL ROSE		0400 C	SANEC	TO ME	60	20895			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		-6-701	7		20 73			
	FFR 27 1995	Sel: As is	0							
	1000	Charles to the same of the sam	Mireally							DHMH-16 Rev 1/89



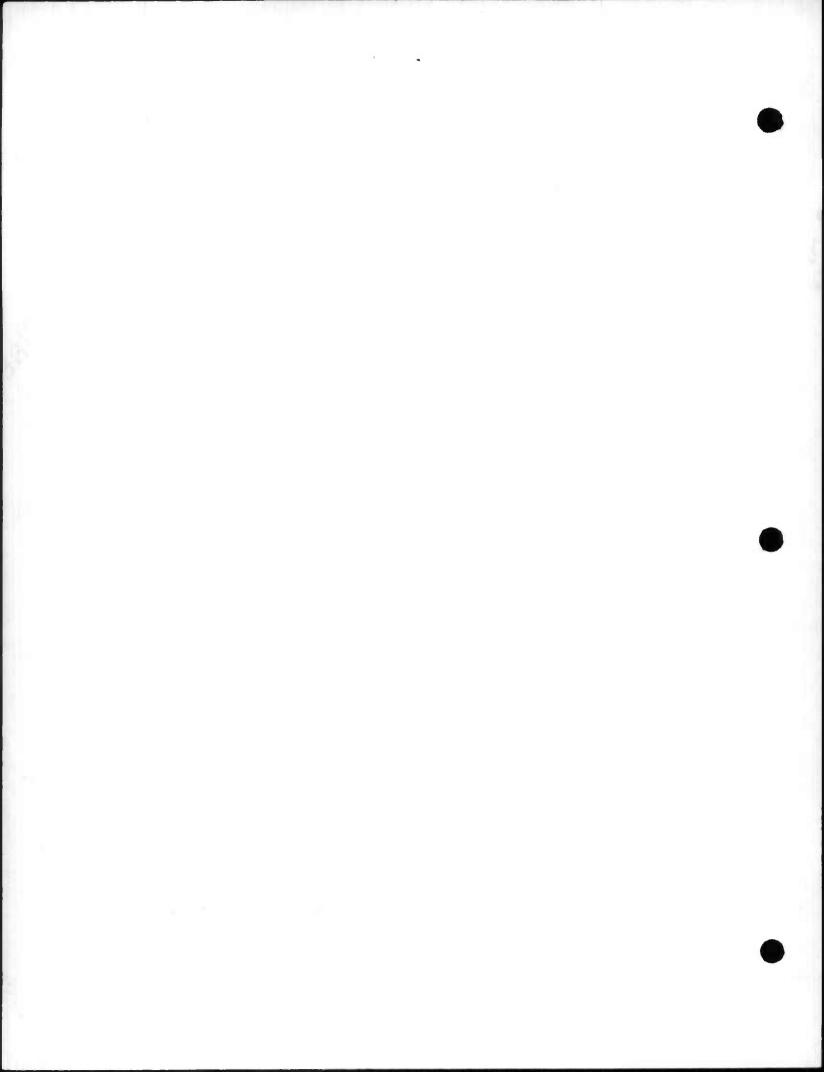
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IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND / DEPART CERTIFIC	MENT OF H	EALTH AND DEATH	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) ROBERT	ERIC	GEORG:	E		2. DATE	e of DEATH	4 199	REAR	7:11 A M
	4. SOCIAL SECURITY NUMBER 218-84-2815	1 🔼 M 2 🗆 F	32 _{YRS.}	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Feb	of BIRTH th, Day, Year)		Country	aska
TOR	9a. FACILITY NAME (If not institution, give physician memori RESIDENCE OF DECEDENT	,		La P	LATA	EATH		9c. COUNT CHARI		ATH
DIRECTOR	10s. STATE 10b. COUNT	rles	10e. CITY, LaP	lata	ION				- 1	10d. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 121 Cardinal C			101	20646				S.A	IAT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 NO	If yes, sp	ENDENT OF HISPAI ecity Cuban, Mexico 2 NO Specif	in, Puerto		or No 14	Black,	- American Indian, White, etc. White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfe. Do NOT use i	rk done during mo retired.)		16	b. KIND OF BUS	CONTRIVER	TRY	
PMP	17. FATHER'S NAME (First, Middle, Lest)	2	Artist		16. MOTHER'S NA	ME (Simi		ctist		
BEC	Robert L. Geor	ge					e Fari	,	rge	
10 8	19a. INFORMANT'S NAME (Type/Print) Robert L. Geor	.se			nd Number or Rural	Route Nun	nber, City or Town	, State, Zip Co	ode)	
.	20a METHOD OF DISPOSITION				L Crt.					
	1 Buriat 2 Cremation 3 Ram 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF		em. 3,	12/9	Sev:	iervi	116	, Stata e, Tenn.
	21. SIGNATURE OF FUNERAL SERVICE LI	Echol	MOO945	AREH P.O.	ART-ECH Box 56	IOLS 7 L	FUNE	RAL H	10ME 206	I,INC.
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	List only one cause	PLE TAY (A) AS A CONSEQUENCE OF):		de of dying, suc	h aa car	diac or reapir	atory srres	t,	Approximata interval Between Onset and Death
CERTIFICATION	Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST	c	AS A CONSEQUENCE OF):					740		
MEDICAL (PART II. Other significant condition	ns contributing to dea	ath but not reaulting in	the underlying	csuse given in	Part I.	24a. WAS AN PERFORI	WEO?	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
Z.	DID TOBACCO USE CONT	RIBUTE TO CAUS			UNCERTAIL	v 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 15 YES 2 NO	HOSPITAL: 1 □ Inpetient 2 X ER		THER:						
F	27. MANNER OF DEATH	28a. DATE OF INJI (Month, Day, Y	URY 285 TIME C	OF 28c. INJ	S □ Residence		SCRIBE HOW IN	JURY OCCUP	RED	STOTHER CAR
BY	1 Natural 5 Pending 2 Accident Investigation	2 24	95 06311	1 □ Y	ES 2 NO		EN OF	ORT	acc	MINWOISIN
밀	3 Suicide 6 Could not be 4 Homicide detarmined	building, atc.	JURY — At home, farm, atre (Specify) の心 Dw ヘッ	et, tectory, office		City	Or Town, State)			CONY MO
COMPLETED		ICIAN: To the best of my	knowledge, death occurred a			to the ca	use(a) and men	ner as stated.		
TO BE C	29h SIGNATURE AND TITLETOF CERTIFIES	rell			O.C.M.	IBER		29d. DATE S	IGNEO (A	fonth, Day, Year) , 1995
	30, NAME AND ACCORDED SOF PERSON WHE	KORFLI M	(A) 111 Penn		, Baltim	ore,	Maryla	and 21	201	
	MAR 0 6 1995	22. REGISTRAR'S	SIGNATURE							



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THE HOOF HALL ON ALLENDING FILLDONING. THE BEST HOUSE WE WAS A CANADA WHILE HOOF A HIGH BOOK TO BE THE HOOF THE) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1	8	ADOUTANT: It from 20 to marked or from 23 shows one fairner or other transmission avaination must be marked as an experience of the market or
2	10	4	95

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH February 27 1995 ALMA B. GARVEY 12:12 p 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) August 23 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F 93 Mid 214-52-1917 1901 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Moran Manor Nursing Home Allegany Westernport 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Marvland Alleganv Westernnort 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Rt.1 Box 404. Horserock Road 21562 US 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES A 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. It yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify: White В 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementery/Secondery (0-12) College (1-4 or 5+) Homemaker Unknown Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Charles Brandlen Amanda Fisher BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jane Biggs Rt. 1 Box 404. Westernport. Md. 21562 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Buriel 2 Cremetion 3 - Re Philos Cemetery March 2. 995 4 Donation 5 Other (Specify) Westernport. Md 22. NAME AND ADDRESS OF FACILITY
Boal Funeral Home SIGNATURE OF FUNERAL SERVICE LICENSPE 111 Church St. Westernport. Md. 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata intervai Between shock, or heert feilure. List only one ceuee on eech line IMMEDIATE CAUSE (Final **Onset and Death** Caudio Dulm. disease or condition resulting in death) Um RHOWL DUE TO (OR AS A CONSEDUENCE OF): MEDICAL CERTIFICATION Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING 4 Therese CAUSE (Disease or injury that initiated evente varelar accider resulting in death) LAST 0,60,000-PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO ension COMPLETION OF CAUSE 1 🗌 YES 2 🙀 NO DF DEATH? 1 TYES 2 TNO Vecrotie Sopre Pa PHYSICIAN: XIC 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER 1 TES 2 P NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 450 No 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural WORK! BY 1 YES 2 NO 2 Accident 26e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of exemin 296, SIGNATURE AND TITLE OF CERTIFIED BE 29c. LICENSE NUMBER 29d, DATE SIGNED (Month. M. D. Feef 140 2

> mahall B. 32. REGISTRAR'S SIGNATURE

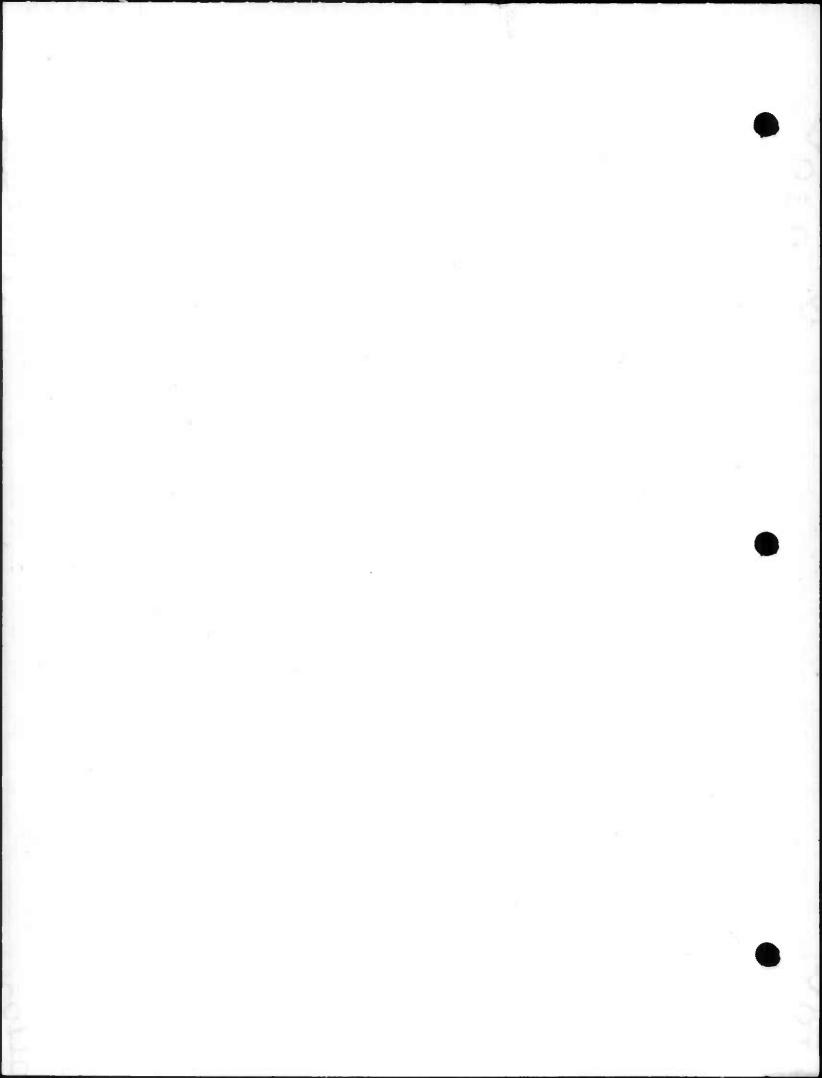
31. OATE FILED (Month, Day, Year)

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ETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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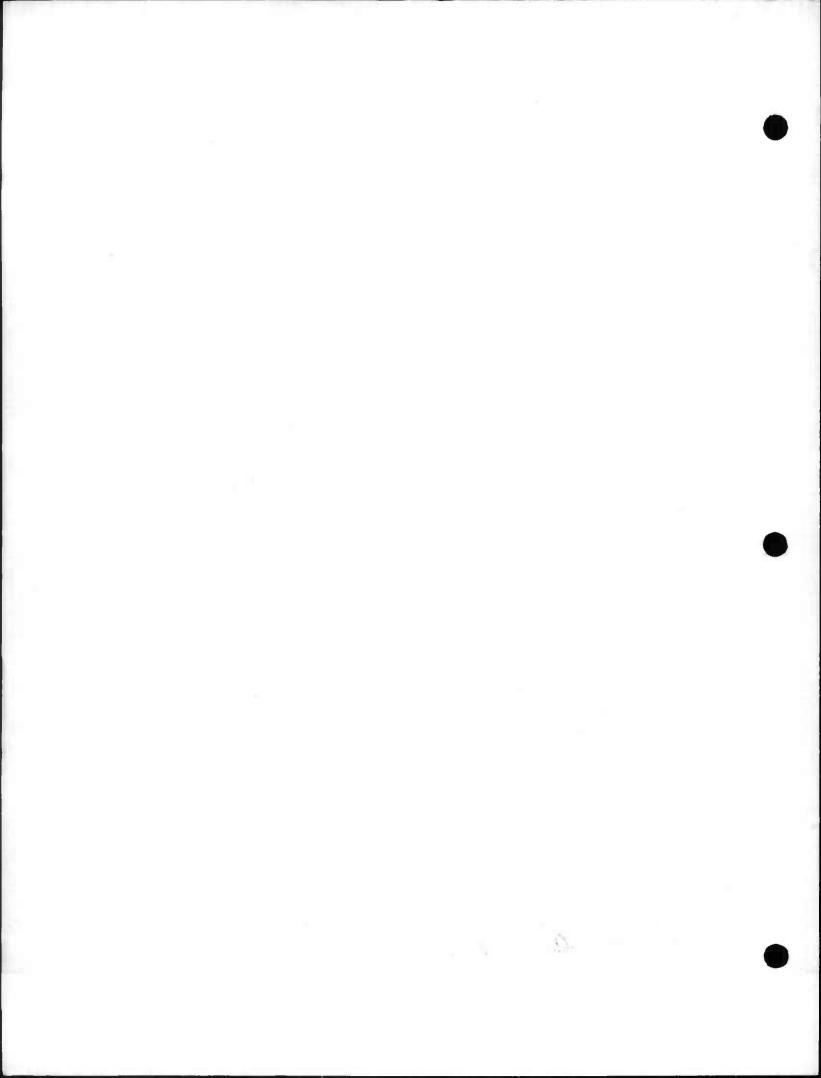
BALTIMORE, MARYLAND 21215-0020 nours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 in the control of the control

the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should Mental Hyglene prior to burial, cremation, or removal. signed by the has been signe Dept. of Health n 23 shows a th the State Ded, or Item 2 with t DIRECTOR: After the hours after death vitem 28 is mark FUNERAL I THE

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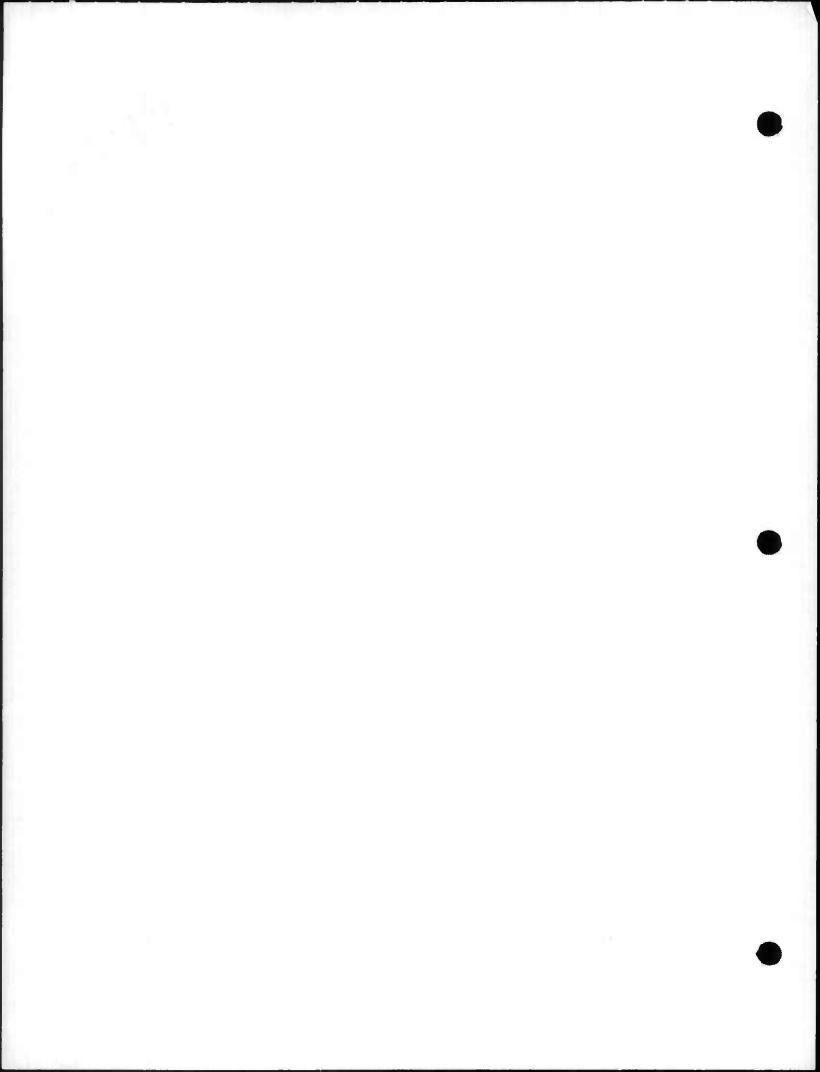
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE STATE Arthur Ellsworth HartleCERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR ARTHUR EILSWORT HARTLE 100 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF S (Month, De) Jan DAYS HOURS 30, 1910 Mary Land 1 🔀 M 2 🗌 F 215-36-7136 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Western Maryland Center Hagerstown, MD 21742-3194 Washington 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Washington Maryland Hagerstown 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 12034 21742 Margaret Drive **USA** 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Po 1 ☐ YES 2 🎇 NO Specify: 1 Never Married 2 2 Married Specify: White IF YES, GIVE WAR OR OATES BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EOUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) farming None farmer dairy 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at William Alice Haupt Hartle BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12034 Margaret Hartle Margaret Drive Hagerstown, Maryland 21742 pe 20g, METHOD OF DISPOSITION
1 (A) Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must ceretery sceneral Ther Cemetery 2/28 Hagerstown, Maryland 4 Donation 5 Other (Specify) examiner MUNITURE OF FUNERAL SERVICE LICENSEE Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory screet, shock, or heert feilure. Liet only one ceuse on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the disesse or condition resulting in death) weeks enmone event, traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentisity list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 6 any injury. PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be determined 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. IMPORTANT: If 2 __ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and menner as stated. BE th, Day, Year 264 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print Jaha d'Author hertell



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MAR 1 1995

	1. DECEDENT'S NAME (First, Middle, I					F DEA		REG. NO 2. DATE OF DEATH			3. TIME OF DEATH
	Arnold Lee HES	SS						February	26,	1995	0648
	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. la:	MO	UNDER 1 YEA		24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Count	HPLACE (State or Foreigny)
	219-54-1011	1 X M 2 F	44	YRS.				March 25,		Wes	st Virgin
Œ	9a. FACILITY NAME (If not institution,) Washington Cour			.98	b. CITY, TOV	N OR LOCATI				INTY OF D	
18	RESIDENCE OF DECEDEN					падел	SLOV	WII	Wa	ISHII	ngton
DIRECTOR	Maryland 106. Co	Washington		10c. CITY, TO				<u> </u>			10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	washington		n.	agers						1 TYES 2 N
RA	113 Broadway #3	3				2174			10g. CIT		WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AF	RMED	13. WAS	DECENDENT (OF HISPAI	NIC ORIGIN? (Specify Yes	s or No	14. BACI	F American Indian
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FDRCES? 1 X	R OR DATES	NO		apecify Cubi		in, Puerto Rican, etc.) y:		Spec	k, White, atc. //y:
0	15. DECEDENT'S	Vietn									white
ETE	(Specify only highest) Elementary/Secondary (0-12)	grade completed)	/G	ECEDENT'S USU Give kind of work I. Do NOT use re	done during	most of working	ng	16b, KIND OF BU	SINESS/IN	DUSTRY	
	10	College (1-4 or 5 +)		cab:	le wr	apper		boat cal	ble m	nfg.	
COMP	17. FATHER'S NAME (First, Middle, Last	7						ME (First, Middle, Malden	Sumame)		
Lut -	Clyde Leroy Hes	SS						Mae Shade			
TO B	19a. INFORMANT'S NAME (Type/Print) Mary R. Hess		19	6. MAILING AD	oadwa	et and Number	or Rural	Route Number, City or Town	m, State, Zip	and 2	1740
	20a. METHOD OF DISPOSITION		_	AND DATE OF D			1145		CATION -		
	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State		ematory or other gerstov			v 3			-	Maryland
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	-	0	22. NAMI	AND ADDRE	SS OF FA	CILITY	30200	,	1142) 24114
3	1 Catt	Mun	nel	7				RAL HOME Blvd.,Hag			(1 017/0
	23. PART i. Enter the diseases,	or complications that	caused the de		1 417	71 0 14 7 7	2011	DIVI., Hag	EISCO	WII or.	Id. 21/40
			COURSO (116 OF	eath. Do not	enter the	mode of dy	ing, euc	h aa cardiac or reap	iratory an	reat.	
	ahock, or heart falls	ure. List only one ceuse	on each ilne	eath. Do not	enter the	mode of dy	Ing, euc	h as cardiac or reap	iratory ar	reat,	Approximate Interval Bets
	ahock, or heart failing immediate CAUSE (Fine) disease or condition resulting in death)	ure. List only one ceuse	e on each ilre	eath. Do not	enter the	mode of dy	Ing, euc	h aa cardiac or reap	iratory ar	reat,	Approximate Interval Bets
	immediate cause (Fine)	ure. List only one ceuse	con each fine	1	enter the	mode of dy	2		iratory ar	reat,	Approximate Interval Bets
	IMMEDIATE CAUSE (Finei disease or condition resulting in death)	DUE TO 10	des des en as a conse	QUENCE OF	enter the	mode of dy	2	h as cardiac or reap	iratory ar	reat,	Approximate Interval Bet
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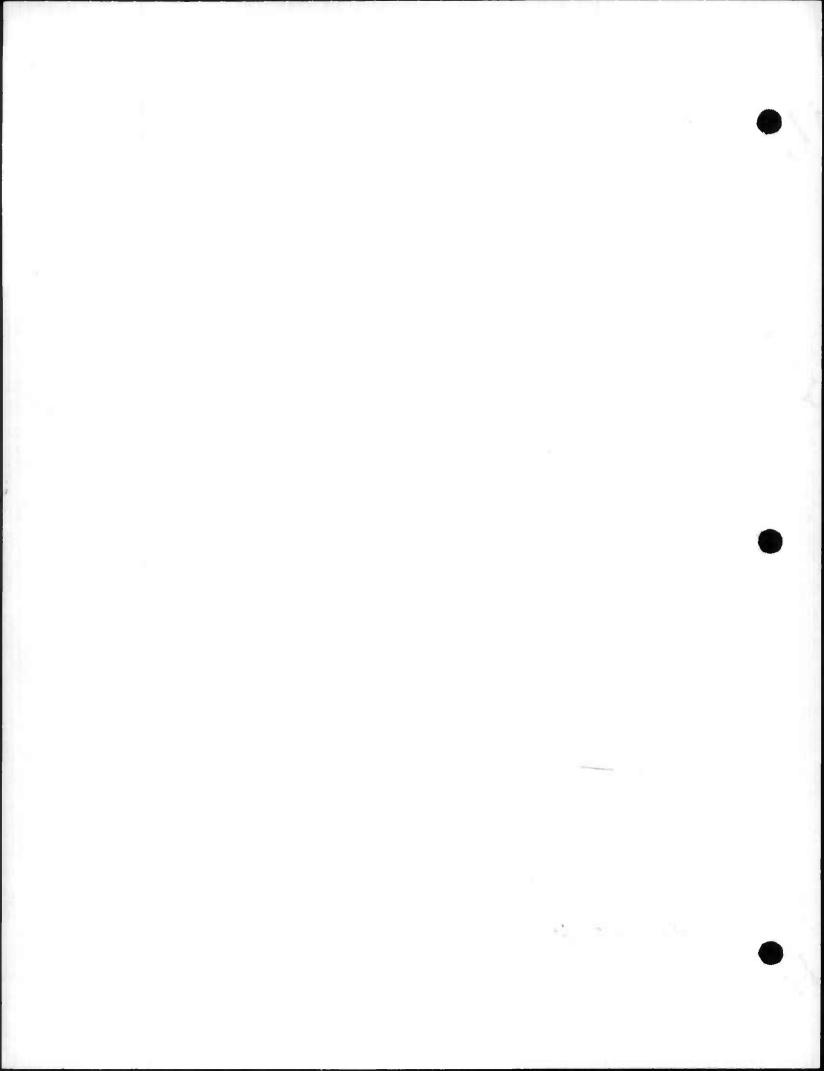
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE	0F	MARYLAND	/ DEPARTMEN	r OF	HEALTH	AND	MENTAL	HYG	IENE
			FRTIFICATI	= 0	FDEAT	ГН		DEC	NO

		**								
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	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. les		IF UNDER 1 YEA	R IF UNDER 24 HRS.	FEB 7 DATE	24 OF BIRTH	1995	10:35 BIRTHPLACE (State or
	220-58-2847	1 💢 M 2 🗆 F	42	YRS.	MONTHS DAY		Jun	Day Mari	1952	Pennsylvo
	9e. FACILITY NAME (If not institution, git	ve street end number)			9b. CITY, TOW	N OR LOCATION OF D		,		Y OF DEATH
DIRECTOR	WASHINGTON COUN	TY HOSPITA	L		HAGEF	RSTOWN			WASI	HINGTON
E	RESIDENCE OF DECEDENT 10a. STATE 10b. COU			10c. CITY	, TOWN OR LO	CATION				10d. INSIDE CI
	Md.	Washingto	n		Smi	ithsburg				LIMITS?
FUNERAL	12835 Greens	bwrg Rd.				101. ZIP CODE 2178	3		10g. CITIZE	U.S.A
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2 N	MED	If yes,	PECENDENT OF HISPA specify Cuben, Mexic res 2 NO Speci	en, Puerlo I	7 (Specify Yellican, etc.)	e or No- 14	4. RACE — American in Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S E (Specify only highest gr	DUCATION ade completed)	16e. DE	CEDENT'S	USUAL OCCUPA	ATION most of working	16b	KIND OF BU	SINESS/INDUS	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	Mis.		ork done during a retired.) Laboret			01	chard	
ğ	17. FATHER'S NAME (First, Middle, Last)									15
	Clifford	l G. Himes	Jr.			16. MOTHER'S N	Ruth	v. Mar	rahan	
O BE	19e. INFORMANT'S NAME (Type/Print)		19b	MAILING .	ADDRESS (Street	et and Number or Rural	Floute Numb	oer, City or Tow	n, State, Zip Co	ode)
2	Lee A. Himes		6	W. U	Vater S	St. P.O. 1	3ox 1	79 Smi	ithsbw	rg, Md. 217
	20a METHOD OF DISPOSITION 1		20b. PLACE A	ND DATEO	FDISPOSITION CyplaCeme	Name of extery 2-2	8-95	Smi	iths bw	rg, Md.
	21. SIGNATURE OF FUNERAL SERVICE		_		22. NAME	AND ADDRESS OF F	ACILITY	12	525 Bro	adhuru Ave
	> rennis	X Nav	2		17/01	11 X FIINOMI	al Ho	me.	111.1	111 010
	23. PART I. Enter the diseases, or shock, or heart failur immEDIATE CAUSE (Final disease or condition resulting in death)	or complications that re. List only one caus	caused the dea	CARDIC	OVASCULA		ch as card	Smu liac or reapi	iratory arrea	rg, Md. 217 it, Approximately Interval Onset an
TIFICATION	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. ARTERIOSI DUE TO (c	caused tha dece on each lina.	CARDIC UENCE OF	OVASCULA D:	noda or dying, suc	ch as card	Sma diac or reapi	CNSDW iratory arrea	it, Approxii
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MEDICAL	snock, or near failure immediate (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. ARTERIOSI B. DUE TO (C	CLEROTIC OR AS A CONSECTION OR AS A CONSECTION OR AS A CONSECTION OR AS A CONSECTION DRAS A CONSECTION	CARDIC UENCE OF	DVASCULA	R DISEASE	Part I.	24a. WAS AN PERFOR	AUTOPSY	24b. WERE AUTOPSY AMAILABLE PRIO COMPLETION DO
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition	ARTERIOS a. ARTERIOS DUE TO (C c. DUE TO (C d	CAUSED THE CONSECUTION OF AS A CONSECUTION OF	CARDIC UENCE OF) UENCE OF) UENCE OF) UENCE OF) 28b. TIME DOA 28b. TIME NJU	DVASCULA DVASCU	Ing cause given in UNCERTAL DOME 5 Residence NJURY AT WORKY YES 2 NO Title end place, end due, death occurred at the	Part I. 8 Other 28d. DES 28d. LOCI City of the cause time, date	24a. WAS AN PERFOR 1 VES 2 (Specify) CRIBE NOW filter for Town, State)	AUTOPSY RMED? I NO NJURY OCCUR and Number or there as stated, and due to the co	24b. WERE AUTOPSY AMAILABLE PRIO COMPLETION DF OF DEATH? 1 YES 2 RED Rural Route Number, cause(s) end menner ee
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition	ARTERIOS a. ARTERIOS DUE TO (C b. DUE TO (C c. DUE TO (C d	CAUSED THE CONSECUTION OF AS A CONSECUTION OF	CARDIC UENCE OF UENCE OF UENCE OF Taulting ir TH YES E OF DEATP DOA 28b. TIME INJU The death occurred twestigetion	DVASCULAL DVASCULAL	Ing cause given in UNCERTAL DOME 5 Residence NJURY AT WORK? YES 2 NO filee	Part I. N	24s. WAS AN PERFOR 1 (Specify) CRIBE NOW striON (Street or Town, State) se(e) end men and place, an	AUTOPSY MED? I NO NJURY OCCUR and Number or ther as stated, d due to the c 29d, DATE S FEE	24b. WERE AUTOPSY MAILABLE PRIO COMPLETION DO OF DEATH? 1 YES 2 RED Rural Route Number, cause(s) end menner ee



FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

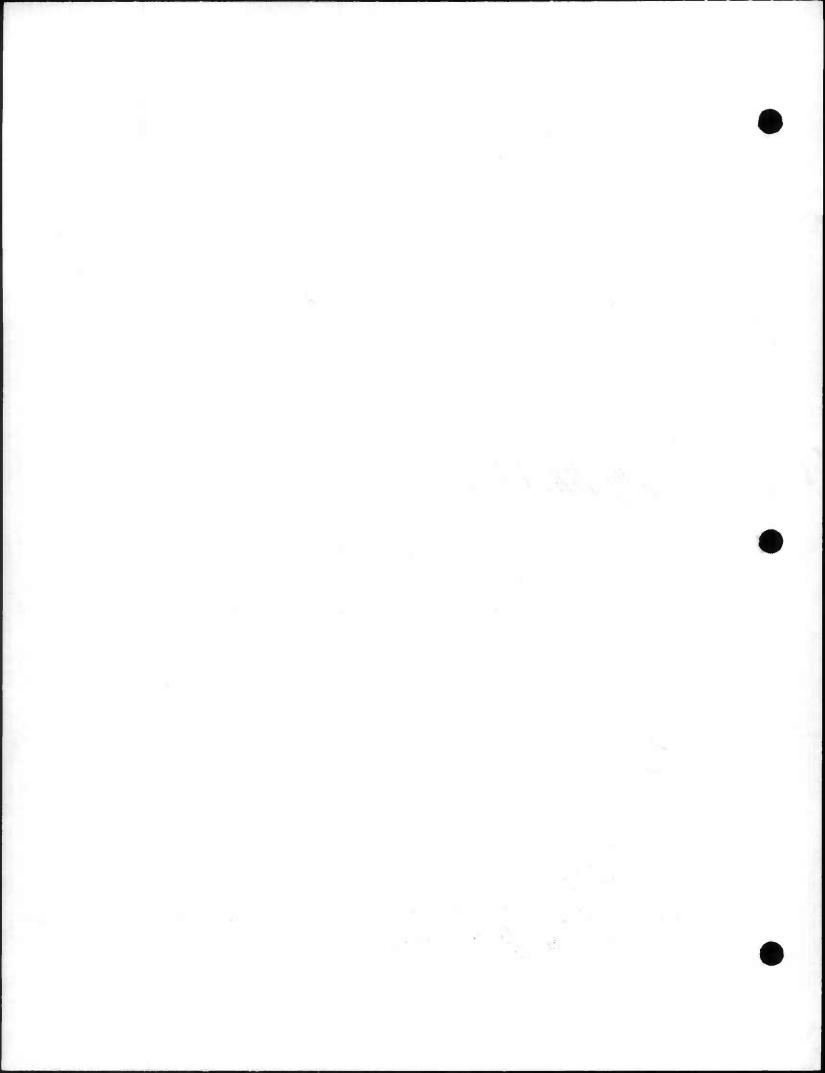
		REGISTRAR CERTIFICATE OF DEATH REG. NO.									
		1. DECEDENT'S NAME (First, Middle, Last)	1 11 1 1 1				2. DATE OF	2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH			
ges 1, 2, 3 should		Anna Elizabeth Hutchinson						February 24 1985		0135A N	
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF	DIDY	a. BIRTHE	LACE (State or Foreign	
		066-22-0693		87 YRS.	MONTHS DAYS	HOURS MIN.	Aug. 5	7,1907	Neu	York	
	~						OR LOCATION OF DEATH				
	힏	Washington County Hospital Hagerstown Washington.									
	EC	10a. STATE 10b, COUNT	Υ	10c. CIT	Y, TOWN OR LOCAT	TION				10d. INSIDE CITY	
. Pages	DIRECTOR	Md.	Washingto	n	Smith	sburg				LIMITS?	
permit		10e. STREET AND NUMBER				. ZIP CODE		10g, CI		AT COUNTRY?	
. usit	FUNERAL	11700 Cecil Ct.				2178	83			S.A	
215-0020 attending physician. se as the burial-transit	5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	ANIC ORIGIN? (S	Specify Yea or No-	14. RACE	- American Indian	
phy e burn	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES		If yes, specify Cuban, Maxica					Bleck, White, etc. Specify:	
5-0 anding	ED B	White							White		
5		15. DECEDENT'S EDUCATION (Specify only highest grade completed)		(Give kind of	Work done during mo.	ork done during most of working		16b. KIND OF BUSINESS/INDUS			
	2	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT us H (omemaker			Н	lome		
MARYLAND aretained by the hospital 5 should be detached to notified at once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)				E					
	TO BE CO	Daniel Dooley						ME (First, Middle, Meiden Surname) Cavanaugh			
		19a. INFORMANT'S NAME (Type/Print)	19b. MAIL ING	19b. MAILING ADDRESS (Street and Number or Rural Re							
		Richard D. Hutch	inson	11700	Cecil C	t. Smith	Abura	Md 2178	3		
BALTIMORE, after death. Page 6 may be y the funeral director, page noval.		20a, METHOD OF DISPOSITION	201	. PLACE AND DATE			OATE	20c. LOCATION -		o Sinte	
		1 🕅 Burial 2 🗆 Cremation 3 🗆 Rem 4 🗆 Donalds 5 🔍 Other (Specify)	oval from Stata	t. Charle	es Cemeto	eru 2-28	1	Farming			
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE			Les mans and access of the sales and						
ALTIN death. Pag death. Pag funeral di i.		Davis Funeral Home Smith by the 21782									
Dours after of in by the or removal.		23. PART I Finer the diseases or compleations that council the death De sales that the sales tha									
d in or re		anock, or neart tellure. List only one ceuse on each line.									
OX 68760 e be executed within an sician and completely filter frior to burial, cremation, traumatic event, the		disease or condition								Onest and Death	
	1	resulting in death)	DUE TO (OR AS	CONSEQUENCE OF	DUNKY Di	MKKES					
	z		FILAS	TALE K	MEDIAA	FOR HI	-154	DIST	15=	İ	
	흔	Sequentially liet conditions, If any, leading to immediate									
BOX cate be e thysician b prior to	8	Cause. Enter UNDERLYING CAUSE (Disease or injury									
G genty	E	that initiated events OUE TO (OR AS A CONSEQUENCE OF):									
e Hand	CERTIFICATION	resulting in deeth) LAST									
ORDS, that the dea hed by the atl the and Menta any Injury.		PART II. Other eignificent condition	s contributing to deeth b	ut not resulting i	in the underlying	ceuse given in	Part I. 24	I. WAS AN AUTOPSY	24b. V	VERE AUTOPSY FINDINGS	
ORD that the ned by the lith and M any inje	ICAL				PERFORMED?		1	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
S Fear Si	MEDI						[1]	1 YES 2 NO		OF DEATH?	
St. of Fee		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
0	¥	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		OTTOLICIA					
PHYSICIAN: The this certificate with the State	Sic	EXAMINER? 1 YES 2 NO HOSPITAL: OTHER: 4 Nursing Home 5 Rasidence 6 Other (Specify)									
	PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c, INJL	JRY AT		BE HOW INJURY O	CCURED		
	BY	1 Natural 5 Pending 2 Accident Investigation	(Morkii, Day, Year)	INJ	M 1 7	ES 2 NO					
ATTENDING ECTOR: After s after death		3 Sulcide 6 Could not be 26e. PLACE OF INJURY — At home, farm, building, etc. (Specify)			street, factory, office			281. LOCATION (Street and Number or Rural Route Number,			
DIVISION OR ATTENDIN DIRECTOR: Aff hours after de:	E	4 Homicide determined		,,			City or Town, State)				
DINE DIRECT HOURS	2 1	29a. CERTIFIER (Check only 1 CERTIFYING PRYSICAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.									
HOSPITAL FUNERAL within 72	COMPL	one) 2 MEDICAL EXAMINE: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I		200 CLOMATISE AND ENGINEERING					29c. LICENSE NUMBER 29d. DATE SIGNED				
TO THE DE FILED) BE	KP COLLIEN MX			,DL		1555		2124100		
	유	30. NAME AND PODRETS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type-Pyrit) BY THUR 3019 VE.NTRIF. CT. MUERSVILLE MA 21743									
		BUTAYIOR	3019 VENT	RIF. C.	T. 1YICLE	RSVIL	LF. 1	11 21:	743		
		FEB 2 7 1995	32. PERISTRAT'S SIGN	ATURE		711111		77 61/1			
		FEB 2 7 1995) James annos	BUNGALL							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

The field within 2 hours after death with the State Dept. of Health and Mental Hyghele prior to burial, chemation, or removal.

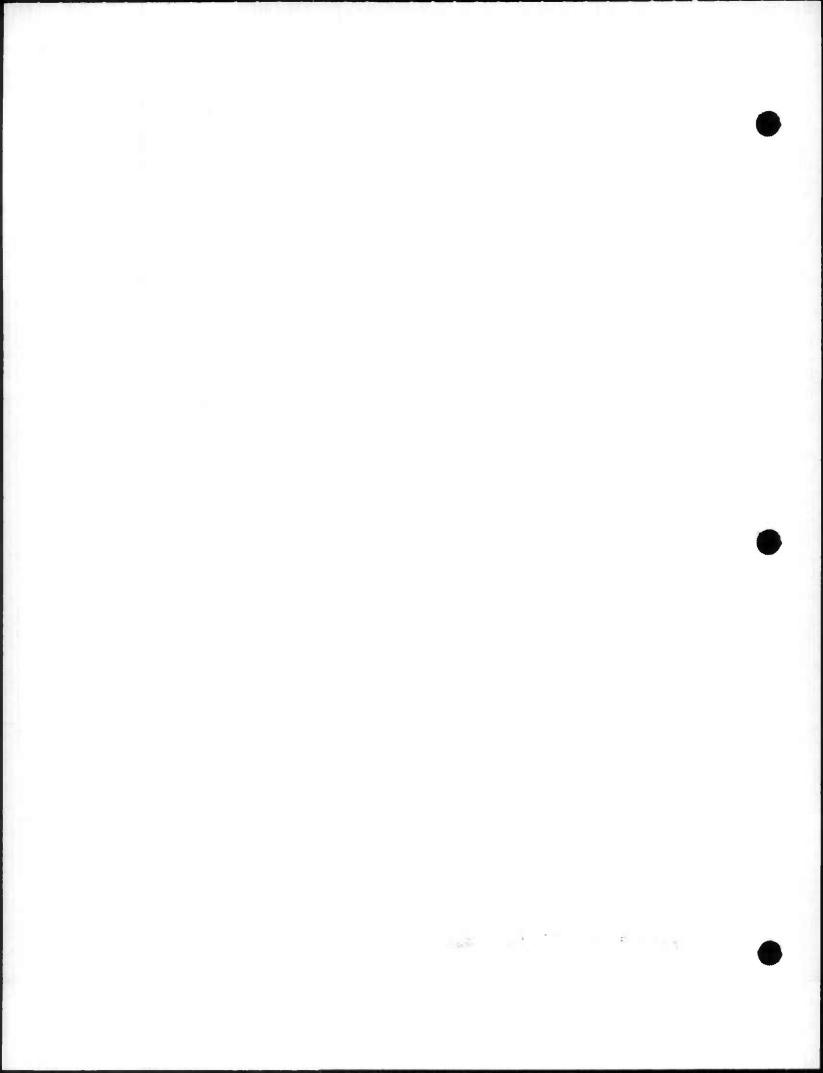
	1 - FOR STATE OF STAT	MARYLAND / DE	PARTMENT OF H	IEALTH AND MI	ENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Lest)				. DATE OF DEATH		3. TIME OF DEATH					
	FLORENCE EVA DU. 4. SOCIAL SECURITY NUMBER 5. SEX				KEB 2	3 19	95 1606 M					
	214-34-0635 9a. FACILITY NAME (If not institution, give street and number)	0,	RS. MONTHS DAYS	HOURS MIN.	Sept. 21, 1	937	BIRTNPLACE (State or Foreign Country) Manyland					
DIRECTOR	Washington County Hospi		Hagerst	OWN	on of Death Sc. County of Death Washington							
EC.	10a. STATE 10b. COUNTY		. CITY, TOWN OR LOCAT	ION	10d. INSIDE CITY							
	Maryland Washington	W	lilliamspor	t			LIMITS?					
FUNERAL	100. STREET AND NUMBER			21795		10g. CITIZE	N OF WHAT COUNTRY?					
N.S.	15225 Clear Spring Rd. 11. MARITAL STATUS 12. WAS DECE	DENT EVER IN U.S. ARMED		ENDENT OF HISPANIC	ORIGIN? (Specify Ver		. RACE — American Indian,					
BY F		1 YES 2 NO E WAR OR DATES	If yes, spe	ecify Cuban, Mexican, i 2 NO Specify:	Puerto Rican, etc.)		Black, White, etc. Specify: White					
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	WILLE										
COMPLETED	Elementary/Secondary (0-12) College (1-4 o	5+) Iffe. Do A	nd of work done during mo. NOT use retired.) VICE Manage		MacDona	1416						
OMI	17. FATNER'S NAME (First, Middle, Last)	J Jei v	Te namage		(First, Middle, Maiden							
BE C	Charles Butler Potts				e Viola C							
10	190. INFORMANT'S NAME (Type/Print) William D. Potts		ite #1 Box				t Va. 25419					
	20s, METHOO OF DISPOSITION 1 Burlai 2 Cremation 3 Removal from State		ATE OF DISPOSITION (Na		DATE 20c. LO		y or Town, State					
	4 Donation 5 Other (Specify)	GreenTawn	Memorial Par	K FED. 2/,		1 amspor	t, Md. 21795					
	· MyAM.U.X.	w_	OSBORNE	FUNERAL HOM	E P.O.BOX	348 Wil	liamsport, Md.					
	23. PART I. Enfar the disesses, or complications shock, or heart failure. List only one	that caused the death.	Do not antar the mod	da of dying, such a	a cardiec or respi	ratory arres	t, Approximats					
	immediate Cause (Final disease or condition resulting in death) Pulmonary edoma.											
	resulting in death) a. DUE	TO (OR AS A CONSEQUENCE	CE OF):	_ /			nows					
N O	Sequentially list conditions,	occurdia	d in	achos	/		year					
ZATI	if any, lasding to immediata cause. Enter UNDERLYING	TO OR AS A CONSEQUENCE	robic ha	art di	CERSO		-					
CERTIFICATION	CAUSE (Disease or Injury that initiated events reaulting in death) LAST	TO (OR AS A CONSEQUENC	CE OF):	WIGG	SCOPE	7						
CER	d											
AL	PART II. Other significant conditions contributing	to death but not result	ing in the underlying	cause given in Pa	rt I. 24a. WAS AN	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS					
MEDIC	Dicheres mellito	5			_ 1 _ YES 2	MO	COMPLETION OF CAUSE OF DEATH?					
Σ.	DID TOBACCO USE CONTRIBUTE TO	VALISE OF DEATH	VES I NO I	UNCERTAIN			1 TYES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF	DEATN (Check only one)	UNCERIAIN								
YSIG	1 VES 2 □ NO 1 □ Inpatient	2 → ER/Outpatient 3 □ DO	OA 4 Nursing Home	5 - Residence &	Other (Specify)							
	27. MANNER OF DEATH 26a. DATE (Month 1 Satural 5 Pending	OF tNJURY , Day, Year)	TIME OF 28c. thuck	JRY AT 28 RK? ES 2 NO	d. DESCRIBE HOW IN	JURY OCCUP	IED					
D BY	2 Accident Investigation 3 Suicide 6 Could not be	E OF INJURY — At home, fa		23	H. LOCATION (Street a	nd Number or	Rural Route Number,					
ETE	4 Homicide detarmined	ng, etc. (Specify)			City or Town, State)							
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best one) 2 MEDICAL EXAMINER: On the best of	of my knowledge, death or faxemination and/or investi	corred at the time, data	and place, and due to the	the cause(a) and man	ner se stated.	sussis) and manner on stated					
ECC	290. SIGNATURE AND THE PERCENTIAN			29c. LICENSE NUMBE			GNED (Month, Day, Year)					
10 10	1000			0268	06	> 7	2/23/55					
	AND AND ADDRESS OF PERSON WHO COMPLETED O	AUSE OF DEATH (ITEM 27)	oh Are	Haspis	Vanu	MS	21742					
	31. DATE FILED (Month, Day, Year) 32. PL 32. PL 32. PL 33. PL 34.	MANUS SIGNATURE	Щ	1								



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KEC	requires
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A	The
2 7	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
5	8
	SPITAL

	-	HEGISTHAH				CERTIF	ICAI	E UF	DEAL	I H		REG. NO			
	,	1. DECEDENT'S NAME (First,									2. DATE C	F DEATH D	AY	YEAR	3. TIME OF DEATH
			hy Lee								Feb.		199		1:13 AM
	-1	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.	.,	IF UNDE	DAYS	HOURS	24 HRS.	7. DATE O	F BIRTH Day, Year)		8, BIRTH Countr	PLACE (State or Foreign
		214-32-4360		1 🗆 M 2 📈 F	60	YRS.			1100113	wiire.		24 19	34		yland
1,	- 1	9e. FACILITY NAME (If not in							R LOCATIO	ON OF DE	ATH		9c. COU	NTY OF D	EATH
	DIMECTOR	112 S. High	Stree	t			Fur	iksto	wn					Wash	ington
- 3	<u> </u>	10e. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCAT	ION				-	1	10d. INSIDE CITY
1 2	<u> </u>	Maryland	Was	hington			I	unks	town						LIMITS?
1:	ا ہ	10e. STREET AND NUMBER						101	ZIP CODE	E			10g. CIT	IZEN OF W	WHAT COUNTRY?
1 8	EHAL	112 S. High	Stree	t					217	34				.S.A	
		11. MARITAL STATUS		12. WAS DECEDENT FORCES? 1			13.	WAS DEC	ENDENT O	F HISPAN	IC ORIGIN?	(Specify Yes		14. BACE	- American Indian
		1 Never Married 2 3 Widowed 4 X Divo		IF YES, GIVE W	AR OR DATES	EZ NO			2 X NO		n, Puerto Ric	en, etc.)		Specif	t, White, etc.
														1	White
	EIED	(Specify only	EDENT'S EDU	completed)		(Give kind of life. Do NOT u.	work done	during mos	ON st of working	g	16b.)	IND OF BUS	SINESS/INC	DUSTRY	
		Elementary/Secondary (0	-12)	College (1-4 or 5 +)							2.5	-			
Once.	5	17. FATHER'S NAME (First, M.	ddle, Lest)			perato	rs E	етре		EDIC MAN				ding	Products
	ا دُ	John F. Nis										ddle, Maiden			
		19. INFORMANT'S NAME (7)				19b. MAILING	ADDRES	S (Street e				odcoc		Code	
	2 ▮	Debra Rice				P.O.									
2		200 METHOD OF DISPOSITI	ON		20b. PLA	CE AND DATE	OF DISPO	SITION (Na		RSCO	DATE		CATION —		wn, State
Tane		1 ☐ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 ⊔ Remi (Specify)	oval from State		Have			rv 2-	-24-9	95				Maryland
examiner		21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE			22.	NAME AN	D ADDRES	S OF FAC	iM YTUK	nnich	Fun	eral	Home
Xa		> 7	ela	ental			4	15 E	. Wi	lson	B1vd	. Hag	erst	own.	Md. 21740
		23. PART I. Enter the disesses, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory srrest, Approximate													
medical	- 1	snock, or ne	eart fellure.	List only one ceus	se on eech l	ine.						o i respi	atory an	oot,	Interval Batween
ě		IMMEDIATE CAUSE (Findisesse or condition	01		Our.	•									Onset and Death
event, the		resulting in death)		DUE TO (OR AS A CON	SEOUENCE O	(<u> </u>	-							7 monder
	<u>.</u>	was a second		h											İ
DTIELCATION	3	Sequentially list conditi if any, leading to immed	liate	DUE TO (OR AS A CON	SEOUENCE O	F):								
TIELCA	<u> </u>	CAUSE (Disesse or Inju		C											
E		that initiated events resulting in death) LAS		DUE TO (OR AS A CON	SEOUENCE O	F):								
1 11	5			d											
6 I	- 31	PART II. Other significa	nt condition	s contributing to d	death but no	ot resulting	In the u	nderiying	ceuse g	iven in f	Part I. 2	4s. WAS AN		24b.	WERE AUTOPSY FINDINGS
1 2	3										,	PERFOR			MAILABLE PRIOR TO COMPLETION DF CAUSE
															OF DEATH? 1 YES 2 NO
		DID TOBACCO U	SE CONTE	RIBUTE TO CAL	JSE OF DI	EATH YE	S 🗆	NO 🗆	UNC	ERTAIN					
SICIAN.	5	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL	26. PI	LACE OF DEAT									
NO A	2	1 YES 2 NO		HOSPITAL:	ER/Outpetlent	3 DOA	OTHE 4 □ Nu		5 PRo	eldence (5 🗆 Other (Specify)			
1 -		27. MANNER OF DEATH	handle -	28a. DATE OF II (Month, Day		26b. TIM	E OF URY	28c, INJU			26d. DEŞC	RIBE HOW IN	JURY OC	CURED	
RV DE	- 1		Pending nvestigation				М	1 🗌 Y	ES 2 [NO					
			Could not be	28e. PLACE OF building, e	INJURY — At	home, ferm, s	street, tac	tory, office			28f. LOCAT City or	ION (Street e Town, State)	nd Number	or Rural R	oute Number,
* L															
0				CIAN: To the beat of n											
COMP	5	2 MEDI	CAL EXAMINE	R: On the beele of exe	mination end/	or investigation	n, In my	opinion, de	eath occure	ed at the t	ime, date e	nd place, end	d due to th	e ceuse(e)	and menner as stated.
P. L		29b. SIGNATURE AND TITLE	OF CERTIFIER	Day 1					29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
TO BE COM		Muhael	4.	Milon	ed				0	416	67			2/2	2/95
15		30. NAME AND ADDRESS OF	PERSON WHO							A		7.1			
		Michael.	S. N	1clorma		179	5	Hoi	rell	Ro	1.	Hage	10/0	wa	MO 21740
		FEB 2 3 199		32. REGISTRAR	S SIGNATURE	E									
		I LD & 0 133.	, ju	a primarie	AND COLLY										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Missing for tuning the physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. UAME DOROTHY EDIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

	REGISTRAR		CERT	IFIC/	TE OF	DEATH	F	REG. NO.			
- 8	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH		3. TIME OF DEATH	1
	Dorothy E. Hub	er					FO D	17	95	~253	H
	4. SOCIAL SECURITY NUMBER 5	. SEX 6. AG	E (In yrs. last birtho	fay) IF t	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF I			NPLACE (Slete or Foreign	0
	198-10-0778	□ M 2 🗗 F	79 YR	S. MON	THE DAYS	HOURS MIN.	9/1/1		Count	aware	
	9a. FACILITY NAME (If not institution, give street	t and number)		9b.	CITY, TOWN	OR LOCATION OF DI	EATN	9c. CO	UNTY OF D	DEATN	
DIRECTOR	Union Hospital				Elkt	on		1			
딥	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		100	CITY TO	WN OR LOCA	TION				10d. INSIDE CITY	
E	Maryland Cecil		1000		levil					LIMITS?	
	10e. STREET AND NUMBER			Dui		H. ZIP CODE		100 0	TIZEN OF	1 TYES 2 X NO	_
FUNERAL	70 Park Drive					21919		log. Ci	USA	WHAT COUNTRY?	
2	11. MARITAL STATUS 1 Never Merried 2 Merried	PORCES? 1 YE			13. WAS DE	CENDENT OF NISPAI	NIC ORIGIN? (S	pecify Yes or No-	14. RACI	E — American Indian, k, White, etc.	-
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR				S 2 X NO Specif		er, metory		"y: White	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION mpleted)	16a, DECEDER (Give kind	d of work o	lone durina m	ION ost of working	16b. KIN	OF BUSINESS/II	OUSTRY		
Elementary/Secondary (0-12) College (1-4 or 5+) 12 Inc. Do NOT use retired.) Secreetary Secretary Health Care											
OMI	17. FATNER'S NAME (First, Middle, Last)		20001		-			le, Meiden Surneme)			_
	Adolf Otto Huber							nes Orr			
BE	t9a. INFORMANT'S NAME (Type/Print)	-	19b. MAII	LINO ADD	RESS (Street	and Number or Rural			Pin Code)		-
2	Dorothy C. Huber					, Earlev					
	20e. METHOD OF DISPOSITION		0b. PLACE AND DA				OATE			num Clate	
	1 Donation 5 Other (Specify)	from State	emetery, crematory Silverbr	or other p	ece)	erv 2	1		- City or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICEN		JII V CI DI	T	22. NAME A	ND ADDRESS OF FA	CILITY		19 0011	, ,,	_
	1322	00 400	-10	1		on Memori					
	23. Part 1 Enter the diseases, or con	KC MOO			2053	Pulaski	Hwy.,	Newark,	DE	19702 Approximate	
	ahock, or heart fellure. List only one cause on each line.										een eath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
2	PART II. Other algnificant conditions of	ontributing to deeth	but not resulti	ng in th	underlylr	ng cause given in	Part I. 24	. WAS AN AUTOPS	248	. WERE AUTOPSY FINDIN	NGS
DICAL								PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUS	E
MED							— ''	YES 2 W NO		OF DEATH?	
	DID TOBACCO USE CO	NITPIRITE TO	CALISE	OF DI	ATH Y	YES IT NO	. Itei			1 YES 2 NO	
A	25. WAS CASE REFERRED TO MEDICAL	/	CAUGE	01 01		LACE OF DEATH (Ch	74				-
SIC		IOSPITAL:	utpatient 3 DO		HER:	me 5 🗆 Residence		nanik i			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJUR	Y 28b.	TIME OF		JURY AT		BE HOW INJURY O	CCURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yee	7)	INJURY		ORK? YES 2 NO					
- 1	3 Suicide 8 Could not be determined	28e. PLACE OF INJU building, etc. (S	RY — At home, te pecify)	rm, street	factory, offi	ce		N (Street end Numb own, Stete)	er or Rural i	Route Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAL EXAMINER: 0	N: To the beat of my kn								e) end menner ee stated	d.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	. /	,			29c. LICENSE NUI	MBER	29d. DA	TE SIONE	(Month, Day, Year)	
TO B	30 MANTE AND ADDRESS OF PERSON WHO S	COMPLETED PERSON OF	ly M	0		10059	15	1	x'd	095	
	DAR DARA	THAR	PUN	7 · Z)	11 61	Du	4	EIK	ton Mo	1
	FEB 2 2 1995	Julia Divide	or Randall				0				
											_

ITEM: 28b, PER NEO FILM g-726 8/23/95 t.t

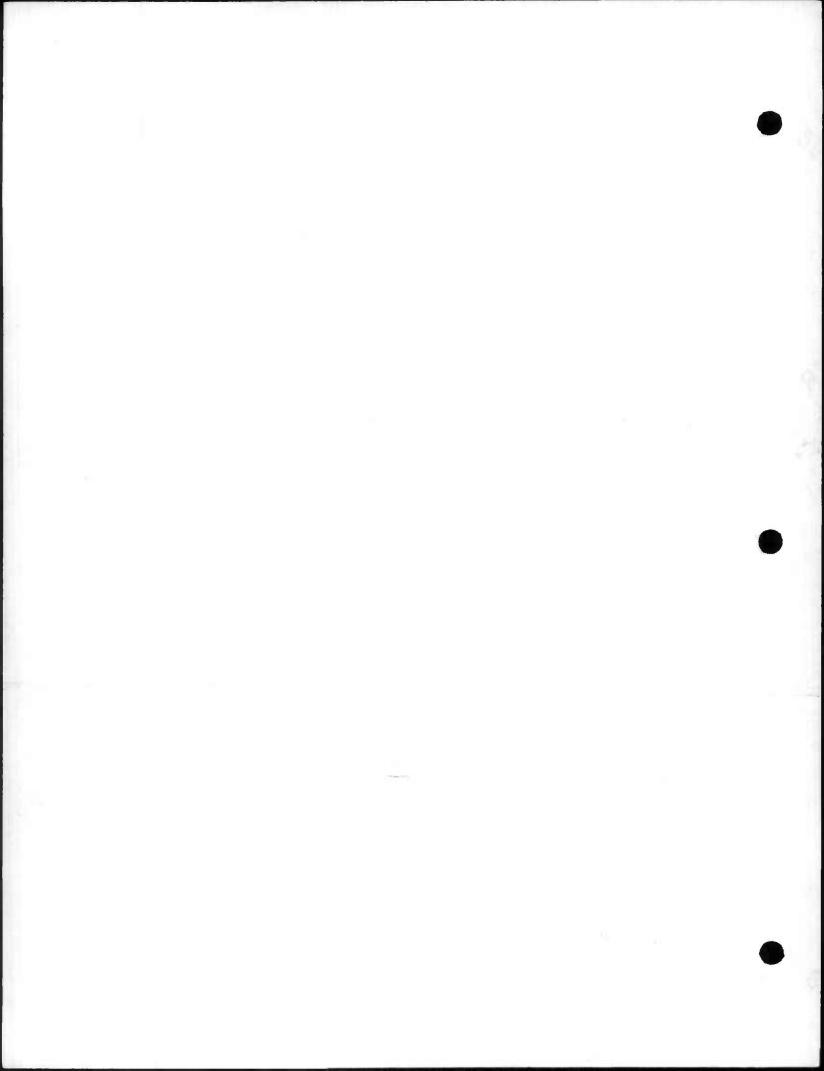
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MAR			MENT OF H		MENT	AL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DA	TE OF DEATH			3. TIME OF DEAT	тн
	WILLIAM	AARON	HUF	ND VI			Mo O	2 2	4 19	95	6:30	Ам
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. les	. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or For Country)					oreign			
	218-72-1511	1 💢 M 2 🗆 F	23	YRS.	ONTHS DAYS	HOURS MIN.		t. 9, 1	1971 Alaska			
œ	9s. FACILITY NAME (If not institution, give a	,		9		OR LOCATION OF D			9c. COUNTY			
DIRECTOR	HARFORD MEMORIAL	HOSPITAL			HAVRE	de GRACI	<u> </u>		HAI	RFOF	KD	
RE	10e. STATE 10b. COUNT	•		10c. CITY,	TOWN OR LOCA						10d. INSIDE CITY	,
0	Maryland	Cecil			Port D						1 - YES 2 X	NO
RAI	100. STREET AND NUMBER 248 Linton Run R	had			101	. ZIP CODE	00/		_		HAT COUNTRY?	
FUNERAL	11. MARITAL STATUS		ED IN U.S. AD	MED	42 990 050		.904			U.S		
	1 Never Married 2 Married	12. WAS OECEDENT EV FORCES? 1 (2)	YES 2 N	10	If yes, sp	ENDENT OF HISPAI ecify Cuban, Mexico 2 NO Specifi	an, Puert	iin? (Specify Yes o Rican, atc.)	or No- 14	Black,	— American India While, etc.	in,
В С	3 Widowed 4 Divorced	1988 -	1989		1 1010	ZA NO Specif	ıy.			Specify	White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G	ive kind of wor	NAL OCCUPATION	ON st of working	.10	6b. KIND OF BUS				
٦	Twelve Years	College (1-4 or 5 +)		Do NOT use i	t Opera	h		Coca-Co	ola En	ter	prises	1
8	17. FATHER'S NAME (First, Middle, Last)		1.0	LKIII	L Opera	16. MOTHER'S NA	ME (FIL			ce.	Maryla	na
Ö	William Aar	on Hurd. V						Pesets				
) BE	19e. INFORMANT'S NAME (Type/Print)		198	. MAILING A	DDRESS (Street a	nd Number or Rural				de)		_
2	Maya J. Hurd					ad, Port D						
	20a. METHOD OF DISPOSITION 1 Burlal 2 A Cremation 3 Rem	ovel from State	20h PLACE A	NO DATE OF	DISPOSITION (No	me of		7	CATION — City		n, State	
	4 Donation 5 Other (Specify)		R.A.	rerris	r place) S & Com	pany		West	Cheste	r, P	ennsylvar	ia i
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			Z2. NAME A	Patters	CILITY					
	P100001	atteror	m. E	Sr.	Perry	rille. Man	rv1a	nd 210	903		ione	
	23. PART I. Enter the diseases, or a shock, or heart fallure.	complications that ce	used the de	sth. Do not	enter the mo	de of dying, suc	h ss ca	rdisc or respi	ratory arreal	,	Approxima	
	IMMEDIATE CAUSE /Final									Onset and		
	disease or condition resulting in death) s. Oue TO (OR AS A COMMISSUENCE OF):											
	_	OUE TO (OR	AS A CONUME	DUENCE OF)	/							
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEC	DUENCE OF):				<u>.</u>			-	
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	c										
E	that initiated events	NO) OT SUD	AS A CONSEC	DUENCE OF):								
CERTIFICATION	resoluting in dealthy CAST	d										
AL O	PART II. Other significant condition	s contributing to des	th but not re	esulting in	the underlying	ceuse given in	Part I.	24a. WAS AN			WERE AUTOPSY FI	
								PERFOR			WAILABLE PRIOR 'COMPLETION OF C	
WE											OF DEATH?	10
ä	DID TOBACCO USE CONTI	RIBUTE TO CAUS				UNCERTAIL	И□					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		To	(Check only one)							
14S	1 🔀 YES 2 🗌 NO 27. MANNER OF DEATH	1 Inpetient 2 XER/		DOA 4	☐ Nursing Hom	5 Residence	_			<u>:</u> _		
	1 Natural 5 Pending	(Month, Day, No		286 TIME C	PF 28c. INJ WO	RK?	28d. Di	EŞCRIBE HOW IN	JURY OCCUR	EO	0 1	
) BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJ	IURY — Al hor	me, ferm, stre		_	261. LO	CATION (Street o	nd Number or I	Rural Ros	ute Number.	. 0
	4 Homicide determined	building, etc.	(эреспу)	stree	+		Cit	y or Town State)	40 Ea	1 01	f Hatem!	ld
2	29a. CERTIFIER (Check only	CIAN: To the beat of my is	nowledge, des	ath occurred a	rt Ihe time, date	and place, and due	to the c	euse(a) and man	ner as stated.			
COMPLETED	one) 2 MEDICAL EXAMINE									ruse(s) a	and manner sa st	sted.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1 10				29c. LICENSE NUM	MBER		29d. DATE SI	GNED (A	Month, Day, Year)	
10 8	Slever	& Chute 4	2			O.C.M.	E.		▶ FEE	. 2	5 199	5
-	30. NAME AND ADDRESS OF PERSON WHI							-				
	Dennis J. Chute,		III Pe	nn Sti	reet, B	altimore	Ma	aryland	2120	1		
	FFB 27 1995	12, REGISTRAR'S	A POST	4								
												- 1

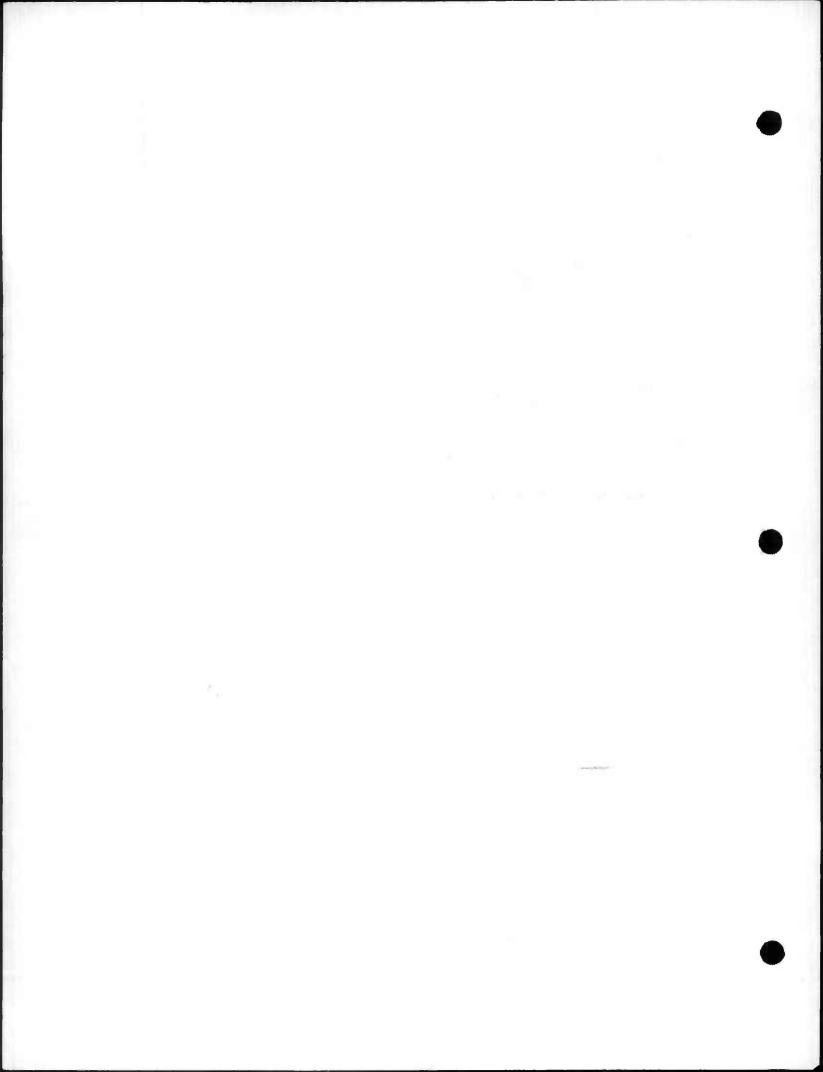


DWG

ITEM: 23 PART I, (B) PER MEO FILM G-722 4/15/95 t.t ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/30/95 t.t 95 07830

1 - STATE

	REGISTRAR	CERTIF	CATE OF	DEATH		REG. NO.					
	SCARLET T (Ann) A.	ŀ	HEDGES		MONT	OF DEATH		YEAR	B. TIME OF DEATH		
		yrs. last birthday)		I			4	95	1:04P M		
	511-76-5045 1□M2⋈F 3	32 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Oct	of BIRTH th, Day, Year) 25 196	2	Miss			
_	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
DIRECTOR	3241 CRISLYNN DRIVE ANNAPOLIS ANNE AR										
HE I	10a. STATE 10b. COUNTY	10c. CITY	, TOWN OR LOCAT	TION				1	Od. INSIDE CITY		
	MD Anne Arundel		Annap	oolis				1	LIMITS?		
AL	10e. STREET AND NUMBER		101	. ZIP CODE			10g. CITIZ	EN OF WH	AT COUNTRY?		
띨	1158 Ramblewood Drive			214	01		Uni	ted	States		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	XXNO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— It yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 YES 2 O Specify: 1. RACE — American, Parto Rican, etc.) Specify: Specify:						White, etc.		
	15. DECEDENT'S EDUCATION	6a. DECEDENT'S	USUAL OCCUPATION	DN .	161	. KIND OF BUS	INESS (IND)		WITTEE		
ETED	(Specify only highest grade completed)	(Give kind of w	vork done during mo	est of working	160	A KIND OF BUS	HNESS/IND	USTRY			
4	Elementary/Secondary (0-12) College (1-4 or 5 +)	Optici	an			Optica	1				
COMPL	17. FATHER'S NAME (First, Middle, Last)	0,000	Q11	16. MOTHER'S N							
BE C	Robert Ballard					E. Ha					
10 B	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street a	and Number or Rura	I Route Num	ber, City or Town	n, State, Zip	Code)			
ř	Thomas M. Hedges	1158	Ramb I ew	wood Dr.	Anna	polis,	Mary	land	21401		
	20s. METHOD OF DISPOSITION 20b. Pl 20b. Pl 20b. Pl 20b. Pl 20create	LACE AND DATE O	F DISPOSITION (Na	me of 3/	1/95	E 20c. LOC					
	4 Donation 5 Other (Specify) La	kemont l	vernorial	Garden	S	Da	vidso	nvil	le, MD		
	21. SIGNATURE OF FUHERAL SERVICE DICENSEE		22. NAME AN	ID ADDRESS OF F	ACILITY	hn M.	Taylo	r Fui	neral Home		
	1JOHER - Xelann		14/ L	ouke of (Glouc	ester	St. A	nnapo	olis, MD		
	23. PART I. Enter the diseases, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) INTRACRANIAL HEMORRHAGE DUE TO (or AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST E. RUPTURED BERRY ANEURYSM DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d										
DICAL	PART II. Other significant conditions contributing to deeth but	not resulting l	n the underlying	g couse given le	n Part I.	24a. WAS AN / PERFORI	MED?	A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?		
ME	DID TORACCO LICE CONTRIBUTE TO CALICE OF	DE 4711 1/2				•		1	YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL 26.	PLACE OF DEAT		UNCERTA							
S	EXAMINER? HOSPITAL:		OTHER:								
¥	YXYES 2 NO 1 □ Inpetiant 2 □ ER/Outpeti. 27. MANNER OF DEATH 26a. DATE OF INJURY	ent 3 DOA	4 Nursing Hom		1						
BY PI	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	JNJI	JRY WO	RK?	28d. DE	SCRIBE HOW IN	IJURY OCC	URED			
	3 Suicide 6 Could not be detarmined detarmined	At home, farm, s	treet, factory, office		28t. LOC City	ATION (Street as or Town, State)	nd Number o	or Rural Rou	te Number,		
H									11		
AP.	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the basic of examination as								nd manner as stated		
5 1						- Prince, and	2 10 1110		== stateu,		
COMPLETED				00- 1105110	HADEC						
BE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU					Conth, Day, Year)		
	296. SIGNATURE AND TITLE OF CERTIFIER SO. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	1 (ITEM 27) (Type,	Print)	O.C.1	4.E.		▶ FI	EB.	26/95		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER June 1 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	1 Penn	Print) Stree	O.C.1	4.E.	re, Ma	▶ FI	EB.	26/95		



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within four ster death. Page 6 may be retained by the brospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burlat. cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARY		MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.							
1. DECEDENT'S NAME (First, Middle, La FLORENCE ELIZAR		HALL		2. DATE OF DEATH MONTH DAY	1995 YEAR	3. TIME OF DEATH 8 & A M					
4. SOCIAL SECURITY NUMBER 216-18-0757	5. SEX 6. AGE	(In yrs. lest birthday) 76 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG a 8-1918	9. BIRTI Count	" MD					
90. FACILITY NAME (If not institution, git 10126 GULFORD R			96. CITY, TOWN OR LOCATION OF D	MD	HOWARI						
10e. STATE 10b. COU	WARD		TOWN OR LOCATION URAL) JESSUP			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
100. STREET AND NUMBER 10126 gulfo 11. MARITAL STATUS	rd road		101. ZIP CODE 20794		U.S.	WHAT COUNTRY?					
3 Widowed 4 Divorced	1 Never Married 2 Narried FORCES? 1 YES 2 TNO If yes, specify					F HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, Black, White, etc.) Specify: AMERICAN					
(Specify only highest or	HIMEMAKER ATTACANA										
Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) ROBERT EDWARD			16. MOTHER'S N. MARY BOSTO	AME (First, Middle, Malden Su	imame)						
190. INFORMANT'S NAME (Type/Print) EARL HA		19b. MAILING A	ADDRESS (Street and Number or Rural AS 10 E	Route Number, City or Town, 3	State, Zip Code)						
30. HETHOO OF DISPOSITION A.D. Juriel 2 Cremetion 3 R 4 Donation 5 Other (Specify)	iemoval from State	MD, CONATTN	DISPOSITION (Name of OTTACE CEMETERY FEE	DATE 20c. LOCATE LAU	RAL, MD						
21. SIGNATURE OF FUNERAL SERVICE CHARLES E. HI			HOUSE OF HICK	ANNA	POLIS,	MD. 21461 E					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DIA bertes Melli7US DUE TO (OR AS A CONSEQUENCE OF):										
	ilons contributing to daeth STIVE Ifest			Part I. 24a. WAS AN AU PERFORM!	ED?	D. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINERY? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:		26. PLACE OF DEATH (C								
	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJURY AT	8 Other (Specify) 28d. GESCRIBE HOW INJI	URY OCCUREO						
3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29s. CERTIFIER (Check only one) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 3 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
296. SIGNATURE AND TITLE OF CERTI	- Wifee	- MD	D38	190 2	DATE SIGNED	22/95					
MAUN CE	WPFEE M.	965	DSAWIAGO 1	Rend Colu.	usin	741 21045					
FEB 28 199	5 Julia davale	ar Randall									

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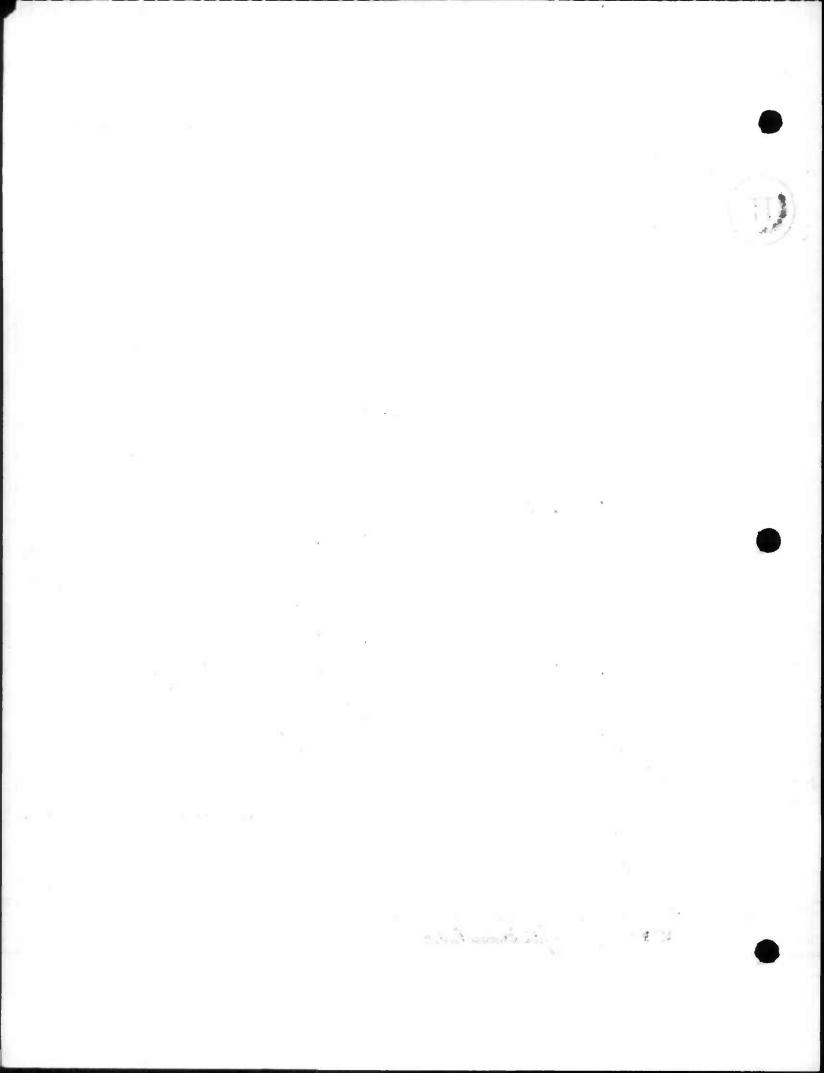
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	OR ATTE	OURS aft	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be filed within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	
	THE HO	THE FU	
	0	2 3	

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

	1 - STATE REGISTRAR	SIAIE UF MA	ANTLAND / CE	RTIF	ICAT	I UF H E OF	DEAT	AND I	MENTA	REG. NO.	E		
1	1. DECEOENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH	v	YEAR	3. TIME DF DEATH
	Waneta Agnes Hov								Mar	ch 1, ™	1995	TEAH	8:00 ам
			B. AGE (In yrs. last		IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE	OF BIRTH	205	8. BIRTI	HPLACE (State or Foreign
1	213 00 1007	1 🗆 M 2 💢 F	65	YRS.			-5-	111		ë 15, 19			yland
DIRECTOR	9e. FACILITY NAME (If not institution, give stre 13320 Porters Lane				96. CITY		ENCOC		EATH			eshir	ngton
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CIT	Y. TOWN	OR LOCAT	ION						10d, INSIDE CITY
E	Maryland Washi	ington					ncock						LIMITS?
FUNERAL	100. STREET AND NUMBER 13320 Porters Lar	ne				101	ZIP CODE					JSA	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	EVER IN U.S. ARM YES 2 XXIN	AED O	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 □ YES 2 ☑ NO Specify: White						lly:			
	15. DECEDENT'S EDUCA (Specify only highest grade co	TION ampleted?	18a. DEC	EDENT'S	USUAL O	CCUPATIO	N st of working		16	. KIND OF BUS	INESS/IN		irce
91		College (1-4 or 5 +)	life.	Do NDT us	se retired.)		St OF WORKIN	y					
COMPLETED	8			Wait	ress	3				Rest	curar	nt	
BE CO	17. FATHER'S NAME (First, Middle, Last) James Porter Hill	L			_		18. MOTH			Middle, Meiden : lkins	Surname)		
5	19a. INFORMANT'S NAME (Type/Print) Lisa Hovermale		19b.	3128	ADDRES:	s (Street a	nd Number nt Ro	or Rural I	Route Num Hanc	ober, City or Town), State, Zi	750	
	20e. METHOD OF DISPOSITION 1 MBurlel 2 Cremation 3 Ramovi 4 Donation 5 Other (Specify)	al from State	20b. PLACE A	nd date	of DISPOS	nete:	me of	3,	/3/9			City or To	wn, State 4D. 21711
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE				NAME AN	D ADDRES	une	ral :	Home		•	
	Seele		NOVE							ncock,			50
	23. PART I. Enter the diseeses, or col shock, or haert fellure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	n only one ceus	e on aach lina.								ratory ar	reat,	Approximeta intervel Batween Onaet and Death
_					BRY PISEASE							LIA	
ATIO	Sequentially list conditions, If any, laading to immadiata cause, Entar UNDERLYING	OUE TO (O	OR AS A CONSEDI	UENCE DI	F):	10	~ ~ ~	. >					40 years
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (D	OR AS A CONSED	UENCE OF	F):	16		14					40 years
- 11	PART II Other algolflaget agoditions												
MEDICAL	PART II. Other algorificant conditions	a To		SAN			ann g	ivan in	Part I.	24a. WAS AN PERFOR	MED?	24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	DID TODA COO HOT CONTINU			KS B	MB								1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL	BUIE 10 CAU	28. PLACE		s 🗷		UNC	ERTAIN	И 🔲	L			
ᅙ	EXAMINER?	IOSPITAL:			OTHE	A:							
ž I	27. MANNER OF DEATH	☐ Inpetient 2 ☐ 1		28b. TIM		alng Home	IRY AT	sidence		SCRIBE HOW IN	IIII OC	CUBED	
	1 Natural 5 Pending	(Month, Day,		INJ	URY	WOI	RK?	ND	200. DE	JOHEL HOW IN	JOH! OC	CONED	
S B√	2 Accident Investigation 3 Suicida 8 Could not be	INJURY — At hon	na, tarm, i	streat, taci				281. LOC	CATION (Street a	nd Numbe	or Rural F	Route Number	
Ë I	4 Homicide determined					- 1	City	or Town, State)					
COMPLETED	29a. CERTIFIER Check only 1 CERTIFYING PHYSICIA	N: To the best of m	v knowledge des	th occum	ed at the t	lime date	and place				_		Hancock MO
Ž) and manner as stated.
CC	296. SIGNATURE AND TITLE DE CERTIFIER						29c. LICE			1			(Month, Day, Year)
	25	Y.	20				00	401	220	_	▶ ~		
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	DF DEATH (ITEM	27) (Туре,	Print)		10	100	100		1.1	pre	n 2, 1995
	Ernest Uzicanin		130 W			54.	Ho	nco	ock	mo	2	175	70
	31. DATE BLED (Month, Day Year)	Divole	Redell	, 1									

· · · · · · ·



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. nours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARY			HEALTH AND F DEATH		YGIENE EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF D	EATH		3. TIME OF OEATH
	GEORGE BENJAM	IN HARMAN				MONTH	DAY C	YEAR 75	0545 M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR		7. OATE OF B	RTH	6. BIRTHP	LACE (State or Foreign
	218-18-5855 9a. FACILITY NAME (If not institution, give	1 MARIGEF	74 YRS.	MONTHS DAYS), 1920 M	ARYL	AND
TOR	CARROLL COUNTY GE		AL		INSTER	DEATH	CARR		ATH
DIRECTOR	MD 106. COUNT CAR	ROLL		N BRID					10d. INSIDE CITY
FUNERAL	100. STREET AND NUMBER 117 PENROSE ST.	101. ZIP CODE 2179	91	10g. CITIZI	U.S	AT COUNTRY?			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 WidowedW_1 100000000000000000000000000000000000	12. WAS DECEOENT EVER FORCES? 1 YES GIVE WAR OR I	2 NO	It yes,	ECENDENT OF HISPA specify Cuban, Maxic ES 2 NO	an, Puerto Rican	acify Yea or No— 1	14. RACE Black, Specific WHI	— American Indian, Whita, atc. TE
COMPLETED	15. OECEDENT'S EDL (Specify only highest grade Elemedary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S I (Give kind of w lite. Do NOT use KILN BUR	ork done during a retired.)	TION most of working		OF BUSINESS/INDU		
ш	17. FATHER'S NAME (First, Middle, Last) FRANK HARMAN				18. MOTHER'S N	AME (First, Middle I HYSER	, Maiden Surname)		
TO B	19a. INFORMANT'S NAME (Type/Print) RUTH E. SELBY		196. MAILING 5927 CO	NOVER	RD. TA	Route Number, CANEYTOWN	ty or Town, State, Zip C	MD	21787
	20a. METHOD OF DISPOSITION 1	oval from State C8	b. PLACE AND DATE O metery, cremetory or off LEISTER'S	r DISPOSITION (her place) CEMET		3/1	NR. WEST		n, State STER MD
	21. SIGNATURE OF FUNERAL SERVICE LI), Quy	ler	22. NAME	UNION	BRIDGE,	D. HARTZI	LER	& SONS
	IMMEDIATE CAUSE (Fine)	a. HE PAT DUE TO (OR AS	each line.				or reepiratory arre	st,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	FAILU	RE				WEEKS
PHYSICIAN: MEDICAL C	PART II. Other significant condition NON INSULIN CERESRA	DEPENDENT THE	DIABET		ng cause given in		WAS AN AUTOPSY PERFORMED? YES 2 NO	3	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE C	26. PLACE OF DEATH	S NO		N 🗆			
SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:	91 × 2107.	OTHER:	me 5 Residence	6 □ Other /Soe	c/h/)		
PH	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. II	JURY AT		E HOW INJURY OCCU	PRED	
B	1 Natural 5 Pending 2 Accident Investigation	28 o DI ACE OF IN HID		M 1 [YES 2 NO				
TED	3 Suicide 8 Could not be determined	28a. PLACE OF INJUR building, atc. (Spe	r — At nome, tarm, st icify)	reet, tactory, of	Ica	28t. LOCATION City or Tow	(Street and Number of rn, State)	r Rural Ro	ute Number,
COMPLETED		CIAN: To the best of my know							and manner as stated.
	296 SIGNATURE AND TITLE OF CERTIFIE		 		29c. LICENSE NU				Month, Day, Year)
B C	Chicano)	Chen-	50 n	Deg.	D016	63		126	195
요.	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print)	8 ANC	140 P -			,
	31. DATE FILED (Mooth, Day, Mar) & F	· Tocco	NATURE .		WEST	TMINS	TER, m	8	71157
	FEB 2 8 1995 Jul	A RESTRANT SIG	II.						

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH tehruary tosier EMILY MORRIS TEAN 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. lest birtnday) 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year MONTHS DAYS HOURS 1 M 2 X F January 7, 1931 218-24-5445 YRS. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH PENINSULA REGIONAL MEDICAL CENTER SALISBURY DIRECTOR RESIDENCE OF DECEDENT 10a STATE 10h. COUNT 10c. CITY, TOWN OR LOCATION Maryland Wicomico Salisbury 10e. STREET AND NUMBER 101. ZIP CODE **FUNERAL** 507 Bethel St. 21801 ours after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or If yes, specify Cuben, Mexican, Puerio Rican, etc.) BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 1 Never Merried 2 K Married ВУ 1 YES 2 NO Specify 3 Widowed 4 Divorced ED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Teacher notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Emily Clifford Morris 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Lloyd T. Hosier 507 Bethel St., Salisbury, MD 21801 pe 20e. METHOD OF DISPOSITION
1 A Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must 1 M Buriel 2 Cremetion 3 4 Donation 5 Other (Specify) Wicomico Memorial Park 2/26 the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home signed by the attending physician and compietely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused he death. Do not enter the mode of dying, such as cerdiec or respiratory errect, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition Eran recuiting in deeth) event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed a cir traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate Cause Enter UNDERLYING 00 CAUSE (Diseese or injury other that initieted events resulting in deeth) LAST 6 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. MEDICAL shows any ţ0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL: 1 YES 2 NO flent 2 ER/Outpatient 3 DOA -4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, NE Hitturel 1 YES 2 NO DIRECTOR; After the hours after death was BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 3 🔲 Suicide 99 6 Could not be COMPLETED 28 determined Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. THE HOSPITAL D THE FUNERAL D filed within 72 ho TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER BE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

32 AGGISTRAP'S SIGNATURES

Ybar)

1995

CERTIFICATE OF DEATH

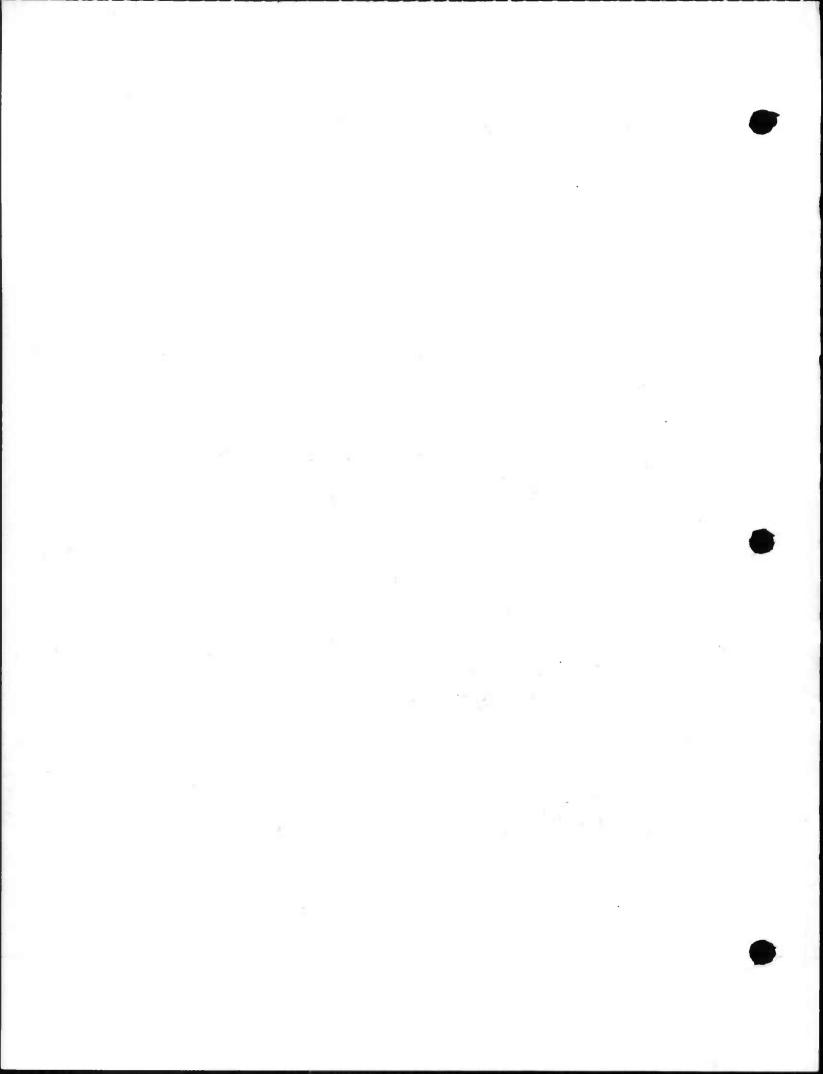
STATE REGISTRAR

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31. DATE FILED (A)

95 07834 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3. TIME OF DEATH 1000 1995 6. BIRTHPLACE (State or Foreign Country) Maryland 9c. COUNTY OF DEATH WICOMICO 10d. INSIDE CITY 1 N YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indien, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Public Education Collins 20c. LOCATION - City or Town, State Salisbury, MD 501 Snow Hill Rd., Salisbury, MD 21801 Approximete Interval Between Onset and Death 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 100 1 YES 2 NO 28d. OEŞCRIBE HOW INJURY OCCURED

29d. OATE SIGNED (Month, Day, Year)



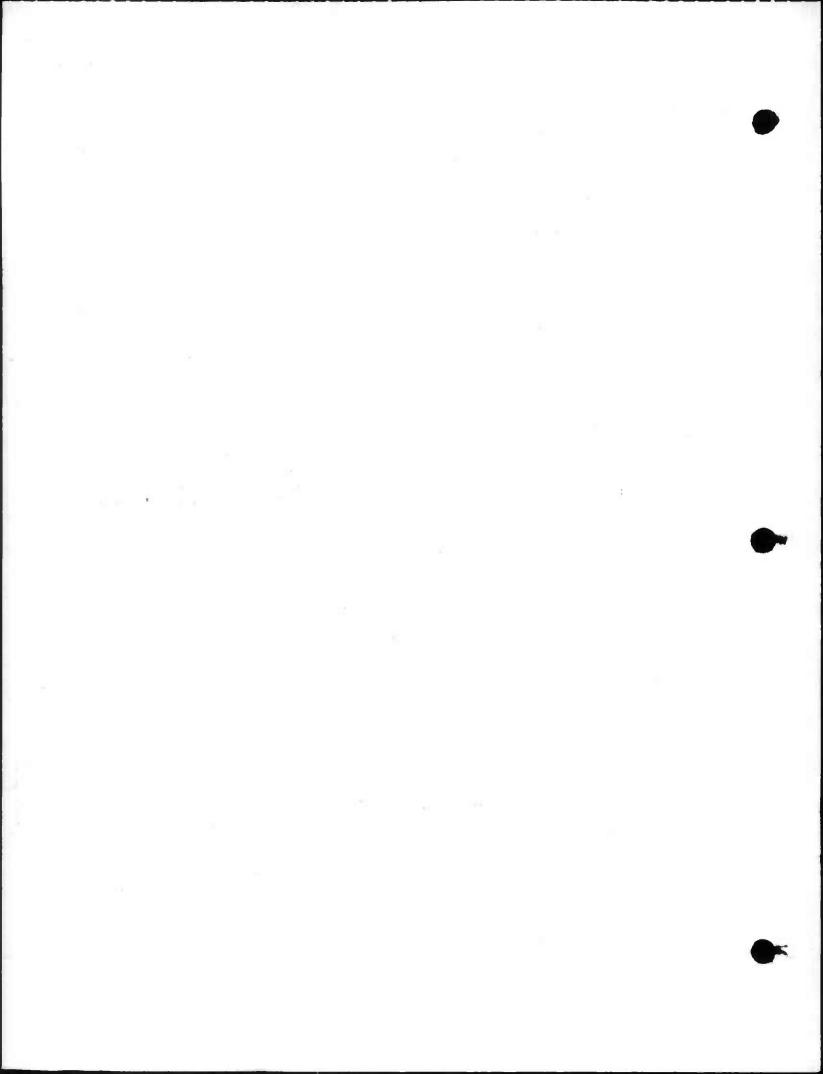
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MA	RYLAND / DEPAR CERTIF	TMENT OF H	IEALTH AND W		GIENE				
	1. DECEDENT'S NAME (First, Middle, Last)	/ /	1	. 1	2. DATE OF DE	EATH				
	FRANCES W. HAMMOND	H	Ammo	SND	FEB	DAY 22	95	0612 TM		
	4. SOCIAL SECURITY NUMBER 5. SEX 6	. AGE (in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTN	8. BIRTHP	PLACE (State or Foreign		
	214-10-6228 1 M 2 X F 9a. FACILITY NAME (If not institution, give street end number)	7 0 272 1 114 1								
DIRECTOR	PENINSULA REGIONAL MEDICAL	CENTER	SALIS				ICOMI			
3EC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d									
	Md. Wicomico	D	elmar				LIMITS?			
IAL	10a. STREET AND NUMBER		10	ZIP CODE		10g. Cl	TIZEN OF WI	HAT COUNTRY?		
FUNERAL	302 E. Elizabeth St.		2	21875		US	USA			
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT IF FORCES? 1 IF YES, GIVE WAF	YES 2 NO	If yes, sp	ENDENT OF NISPANI ecify Cuben, Mexicen, 2 X NO Specify:	, Puerto Rican,	etc.)	14. RACE - Black, Specify	- American Indian, White, etc.		
ED	15. DECEDENT'S EDUCATION	18e. DECEDENT'S	USUAL OCCUPATION	DN	16b. KIND	OF BUSINESS/IN	DUSTRY	MILLEC		
ш	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of v life, Do NOT us	vork done during mo e retired.)	st of working						
MPL	12	Homemak	er			Home				
COMPLETED	t7. FATHER'S NAME (First, Middle, Last)			18. MOTNER'S NAM	IE (First, Middle,	Maiden Surname)				
BE	Ebenezer White			Rosa Ph	illips	White				
0	19e. INFORMANT'S NAME (Type/Print)			nd Number or Rural Ro						
	Fred J. Hammond			abeth St						
	20a. METNOD OF DISPOSITION 1 □XBuriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crematory or of Parsons C	PEDISPOSITION (Na her placa) PMPTPTV	ma of	2-25	Salisbu				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	11418048		ID ADDRESS OF FACI		DUITION	117, 1	iu.		
	raulli in the	/		Funeral	-					
	23. PART I. Enter the diseases, or complications that c	aused the deeth. Do n	of enter the mo	Grove S	t. Deli	mar. De	. 1994	Approximate		
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) ACUTE MYOUSE TRIPE TO LOR FAIL WEE DUE TO (OR AS A CONSEQUENCE OF): VENITAL ON NOTE FINELY TO LORD. B. ACUTE MYOUSE TRIPE TO LORD.									
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): A DUT E MYO CHITTOPIA TO THE TOTAL THE PROTECTION OF THE TOTAL THE									
PHYSICIAN: MEDICAL (PART II. Other significent conditione contributing to de	eth but not resulting in	The underlying	ceuse given in P	1	WAS AN AUTOPSY PERFORMED? YES 2 NO	6	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
2	DID TOBACCO USE CONTRIBUTE TO CAUS	SE OF DEATH YE	S I NO I	UNCERTAIN			'	T YES 2 NO		
M	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEAT	H (Check only one)							
Sic	noselial:	R/Outpatient 3 DOA	OTHER: 4 Nursing Nom	5 Residence 8	☐ Other (Spec	cify)				
ВУ РН	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	JURY 28b. TIME INJI	JRY WO	URY AT RK?	28d. DESCRIBE	NOW INJURY O	CURED			
	3 Suicide 8 Could not be 4 Nomicide determined	NJURY — At home, farm, s . (Specify)	treet, factory, offic		281. LOCATION City or Town	(Street and Numbern, State)	r or Rural Roo	ute Number,		
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my 2 MEDICAL EXAMINER: On the basis of examples of examples.							and manner ee stated.		
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER WELLEN M. Buldan	10 M.I	0	D/US	40	▶ .	2/22/	Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE 547-F RIVERSIDE T	Rive, -	Print)	ury 1	UD	2180	/			
	31. DATE FILED (Morith, Day, Year) FEB 23 1995 Jahra 20	SIGNATURE P								



1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH SHOWN OF THE PROPERTY OF	
1/22 . [2 15 7.	SEAR 3. TIME OF DEATH
1 M 2 F / YRS. MONTHS DAYS HOURS MIN. (1 (Month, Dags) bear) / 9/8	6. BIRTHPLACE (State or Foreign Fountry)
	TY OF DEATH ICOMICO
PENINSULA REGIONAL MEDICAL CENTER SALISBURY PESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CHY, TOWN OB LOCATION 10c. CHY, TOWN OB LOCATION 10c. STREET AND NUMBER 101. ZIP CODE 109. CITIZE	10d. INSIDE CITY LIMITS? 1 YES 2 NO
100. STREET AND NUMBER 100. ZIP CODE 100, CITIZE	EN OF WHAT COUNTRY?
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No— 1 1 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDU: (Specify only highest grade completed)	14. RACE — American Indian, Black, White, atc. Specification
in the life in the second of t	STRY
Va Pla So Plant Proce 17. FATHER'S NAME (First, Middle, Lest) Harry Hill Sr. 18. MOTHER'S NAME (First, Middle, Maiden Surname) Etta Steelman.	
	Malnia 23336
200_METHOD OF DISPOSITION 1	gue, shirginia
and the state of t	
23. PART 1. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arreading the property of the property	Approximate interval Between Onset end Desth
CAUSE (Disease or Injury that initiated events resulting in desth) LAST	
() 0 9 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24b. WERE AUTOPSY FINDINGS
Arin Cadyandin	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
1 & g = S N S S S S S S S S	
EXAMINER? HOSPITAL: 1 Pinpatiant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Raaidenca 8 Other (Specify)	
T 正 も 2 元 1 元 Netural 5 Pending M 1 元 Netural 5 Pending M 1 元 Netural 5 円 Ne	
2 Accident 3 Sulcide 4 Homicide 6 Could not be determined 2 Sa. PLACE OF thJURY — At home, farm, street, factory, office 4 Homicide 6 Could not be determined 2 Sa. PLACE OF thJURY — At home, farm, street, factory, office 6 City or Town, State) 2 Accident 3 Sulcide 4 Homicide 6 Could not be determined 2 City or Town, State)	
Z Z Z = L (Check only (Check only and the cause(s) and the manner as stated	
PPSE O 7) Promission Pos	SIGNED (Month, Day, Year)
106 MILFORD ST, SVITE 104 SALISORY, MD 218	901
31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE FEB 21 1995 Julia Davilson Randell	DHMH-16 Ray 1/89

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATH		3. TIME OF DEATH		
BABY GIRL		Н.	IEARD		Mon	ARCH 4,		6:25P M		
4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH th, Day, Year)	0. 8	BIRTHPLACE (State or Foreign		
	1 🗆 M 2 🗔 🕌	YRS.	NTHS DAYS	2 25		RCH 4.	1995	Country) MD		
9e. FACILITY NAME (If not institution, give stre	set and number)	9b	CITY, TOWN C	R LOCATION OF DE			9c. COUNTY			
THE JOHNS HOPK	CINS HOSPITAL	L	BALT	IMORE CI	TY					
RESIDENCE OF DECEDENT 10e. BTATE 10b. COUNTY		10c. CITY. TO	OWN OR LOCAT	ION				10d, INSIDE CITY		
MD				2018				LIMITS?		
10e. STREET AND NUMBER		I BALI	'IMORE	ZIP CODE			10a CITIZEN	1 YES 2 □ NO OF WHAT COUNTRY?		
828 N. LINWOOD	AVENUE			21205						
	12 WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	VIC ORIGI	N? (Specify Yee	or No.— 14.	SA RACE — American Indian,		
1 X Never Merried 2 Merried	FORCES? 1 YES	2 NO	if yes, spe	2 P NO Specify	n, Puerto	Ricen, etc.)		Black, White, etc.		
3 Widowed 4 Divorced								BLACK		
15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. DECEDENT'S USU (Give kind of work	done during mo-	N st of working	16	b. KIND OF BUS	INESS/INDUST	RY		
Elementary/Secondary (0-12)	College (1-4 or 5+)	iffe. Do NOT use rel	tired.)							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA		Middle, Maiden :	Surneme)			
DUANE COLMA 190. INFORMANT'S NAME (Type/Print)	'N			LATONY		S.		ARD		
Complete Complete Complete St.	N.D.			nd Number or Rural F						
LATONYA S. HEAR				D AVENUE			_			
1 Donetion 8 Other (Specify)	val from State 20b.	PLACE AND DATE OF DI elery, crematory or other p H	ISPOSITION (Na plece)		DAT		CATION — City			
21. SIGNATURE OF FUNERAL SERVICE LICE		1П		MARCH		.995	BALTI	MORE, MD.		
as tome and address of facility										
JOHNS HOPKINS HOSPITAL 600 N. WOLFE STREET 23. PART i. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or reapiratory errest, Approximate										
23. PART i. Enter the diseasee, or co ahock, or haart failure. Li	mplications that caused ist only one cause on ea	the deeth. Do not a	entar the mod	de of dying, sucl	h es cer	diec or reepin	ratory erreet,	Approximate		
IMMEDIATE CAUSE (Final	The state of the s		2			L		Onset and Dasth		
disesse or condition resulting in death)	Intracrani Dye TO (OR AS A	al Hen	ionho	spe in	- u	Tero		less than		
30	DUE TO (OR AS A	CONSEQUENCE OF):	4	V				5 days		
Sequentially liet conditions, b.	Trojound	Aneu	-6-					less than		
if any, leading to immediata cause. Enter UNDERLYING	QUE TO (OR AS A	CONSEQUENCE OF):						5 Starp		
CAUSE (Disesse or injury C.	DUE TO (OR AS A	CONSEQUENCE OF:						less than		
that initiated events reaulting in death) LAST	50E 10 (01 A3/A	CONSCOUENCE OF).						5 days.		
d.										
PART ii. Other significant conditions	contributing to death bu	it not reaulting in th	na undarlying	cauaa given in	Part I.	24a. WAS AN /		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
						1 TENFOR		COMPLETION OF CAUSE OF DEATH?		
							_	1 YES 2 NO		
DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAIN	V M					
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	e. PLACE OF DEATH (C								
	1 Inpatient 2 ER/Outpa		HER: Nursing Home	5 🗆 Residence	8 🗆 Othe	er (Specify)				
27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU		28d. DE	SCRIBE HOW IN	JURY OCCURE	D		
1 Natural 5 Pending 2 Accident Investigation	17.4			ES 2 NO						
3 Suicide e Could not be	28e. PLACE OF INJURY building, etc. (Speci	At home, term, street	t, factory, office		28t. LOC	ATION (Street ar	nd Number or Ru	ural Route Number,		
4 Homicide determined										
29e. CERTIFIER (Check only 1 CERTIFYING PHYSICI.	AN: To the best of my knowle	idge, death occurred at	the time, data	and place, and due	to the ca	use(e) end mani	ner ee stated.			
one) 2 MEDICAL EXAMINER:	On the basis of examination	end/or investigation, in	my opinion, de	ath occured at the	time, date	end place, end	due to the ceu	use(e) and manner se stated.		
296. SHOMENTURE AND TITLE OF CERTIFIER	1		T	29c. LICENSE NUM	BER		29d. DATE SIG	NED (Month, Day, Year)		
D36638 ► 3/4/98							14/98			
NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
ESTRILO G	-Auda	1								
31. DATE FILED WAR 1 5 199	32. REGISTRAR'S SIGNA	TURE ROUL !!								

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF				ID MEN	TAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)							TE OF DEATH		EAR 3.	TIME OF DEATH
			Huffman					F∈	b. 28,	1995		1:00 A M
	9			In yrs. last birthday) 7 7 YRS.	IF UNDER 1	DAYS	IF UNDER 24 H	N. (M	TE OF BIRTH onth, Day, Year)		Country)	ACE (State or Foreign
3 should		9a. FACILITY NAME (If not institution, give street	Δ /	72 YRS.	9b. CITY,	TOWN O	R LOCATION C		ot. 25,	1922 V		
2, 3 sh	OR O	8809 Canberra Drive Clinton Prince George's										
	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY										
Page	OIR	77.57 14.00	George¹s			TOWN OR LOCATION Linton						LIMITS? YES 21 NO
permit		10e. STREET AND NUMBER										T COUNTRY?
an. ransit	FUNERAL	8809 Canberra Driv					2073				SA	
physician. burial-transit permit. Pages 1,		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DA	2 NO	NO If yes, specify Cuban, Maxican, Puerto Rican, etc.)						RACE — Black, W Specify:	American Indian, hits, stc.
attending ise as the	ED BY	I WW II									Whit	e
or afte		(Specify only highest grade com-		(Give kind of life, Do NOT u	work done du	cupation uring mos	N st of working		16b. KIND OF BU	SINESS/INDUS	TRY	
the hospital or detached for u	COMPLET	6	Jonege (I-4 or 5 +)	Carp	enter				Union	1		
	CO	17. FATHER'S NAME (First, Middle, Lest)		18. MOTHER	S NAME (Fin	st, Middle, Maiden						
₹ 2 €	BE (William Robey Huff					ne Penn					
retained 5 5 should notified	5	190. INFORMANT'S NAME (Type/Print) Jacqueline Mary Hu	ıffman						umber, City or Tow			
ay be		20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE	OF DISPOSIT	TION (Na	me of	0	inton,	MD 207		State
9 9 0	1	1 Donation 2 Other (Specify)	from Stata	Azen Bap	ther place)	Chuc	crh Cer		22.24	mascus		
death. Page 6 m s funeral director, l.		21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22. N	AME AN	Fune:	F FACILITY				
after death. by the funera moval.			m M00053	<i></i>	P	. 0.	. Box	156,	Waldorf	, MD 2	0604	-0156
ted with nours after completely filled in by the lal, cremation, or removal.		23. PART I. Enter the diseases, or com shock, or heart failure. List	iplications that caused tonly one cause on ea	the deeth. Do and the line.	not enter 1	he mod	de of dying,	such as c	erdiac or reap	iratory arreat		Approximate Interval Between
y filled tition, c		IMMEDIATE CAUSE (Final disease or condition	an starbetic	c	~-00	1	04.					2 weeks
ompletely fille il, cremation, event, the		Due to (or as a consequence of): Sequentially liet condition: b. Pulmmpry Ashestosis										
executed and corr o burial, natic ev	N	Sequentially list conditions,	Pulmma	y Ash.	stosi	2						
	CATION	if sny, iesding to immediate cause. Entar UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):							
e of a	FIC	CAUSE (Disesse or Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE O	F):							
H) H)	ERTIFI	resulting in death) LAST										
at the death certified by the attending and Mental Hygien is injury, or oth	2	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
- 26 -	ICAI			-		,	STOCK WINE		PERFOI	RMED?	AM CC	ARLABLE PRIOR TO IMPLETION DF CAUSE
v requires that been signed of t, of Health a	MEDIC									2 1000		DEATH?
13 te 13 a	AN:	DID TOBACCO USE CO	INTRIBUTE TO	CAUSE OF	DEATI			NO 🗆				
	ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		OTHER	26. PL	ACE OF DEATH					
SICIAN: The certificate in the State	PHYSIC	1 TYES 2 NO 1 [27. MANNER OF OEATH	28a. DATE OF INJURY	28b. TIN	E OF	28c. INJU	5 Th Reside		ther (Specify) DESCRIBE HOW	INJURY OCCUR	ED	
문 목 등 등	ВУ Р	1 Accident 5 Pending Investigation	(Month, Day, Year)	IN.	JURY	WOI	RK? 'ES 2 NO	-				
0 4 9 W		3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm,	atreet, factor	ry, office		281. L	OCATION (Street Jity or Town, State,	and Number or	Rural Rout	e Number,
OR ATTEN DIRECTOR: hours after Item 28 I	ETE	4 Homicide determined										
로 작전 =	COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER: C									euse(s) ar	nd manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: II	ECC	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE					onth, Day, Year)
THE SE STEED THE S	00	William D. Ju	mer uz.				D35				28/9	
	T	Dr. William T. Tanner 11701 Livingston Rd., #101, Ft. Washingotn, MD 2074									20744	
* 1		31. DATE FILED (Month, Day, Year) MAR 0 2 1995	32. REGISTRAR'S SIGNA				, 11.0			11900117		30711
		MAR U 2 1333	There are more an	- supposely								

FOR

BALTIMORE, MARYLAND 21215-0020

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.	the first of the state of the s	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR		CE		ICATE OF				EG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)					_		2. DATE OF MONTH	DEATH		YEAR	3. TIME OF DEATH		
- 1	ALFRED HENRY,	SR.						Feb	14		1995	0305am		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF E (Month, Da	BIRTH v. Year)		8. BIRTH Countr	PLACE (State or Foreign		
1	217-10-8496	1 M 2 F	8	6 YRS.	MONTHS DATS	HOURS	MIN.			1,19		ryland		
_	9a. FACILITY NAME (If not institution, give s	treet and number)			96. CITY, TOWN		N OF DE			9c. COL	INTY OF D	EATH		
5	Dorchester Genera	al Hospit	al		Cambri	age				Do.	rches	ster		
	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN OR LOCA	TION						10d. INSIDE CITY		
8	Maryland Doro	chester		Car	nbridge							LIMITS?		
7	10e. STREET AND NUMBER		:	Cal		f. ZIP COOE				10g, CIT	IZEN OF W	WAT COUNTRY?		
FUNERAL DIRECTOR	834 Fairmount	Ave.				21613					USA			
3	11. MARITAL STATUS	12. WAS OECEDEN	T EVER IN U.S. AR	MED	13. WAS OE	ENDENT OF	HISPAN	IC ORIGIN? (S	pecify Yes	- American Indian,				
BY F	1 Never Married 2 Married	FORCES? 1	YES 2 N	10		ecify Cuban		n, Puerlo Ricer	ı, etc.)		Black	, White, atc.		
	3 ₩Idowed 4 Divorced	<u> </u>									Specify: Black			
臣	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DE	CEDENT'S	USUAL OCCUPATI work done during me se retired.)	ON ost of working	7	16b. KIN	D OF BUS	INESS/IN	DUSTRY			
2	Elementary/Secondary (0-12)	Conege (1-4 of 5+)						Laı	ındry	7				
COMPLETED	7th 17. FATHER'S NAME (First, Middle, Last)						5010 111							
	Joseph Henry					Mel	vina	ME (First, Middle McGlo	e Maiden Otter	Sumame) 1				
8	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS (Street						n Codel			
2	Alred Alfred Her	rv. Jr.										21612		
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION //Name of DATE 20c. LOCATION — City of Town, State													
. 1	1X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cemetery, cre	matory or o	ther place) Is Cemete	rv		2/17/9			idee			
1	21. SIGNATURE OF FUNERAL BERVICE LIC	ENSEE			82. NAME A	NO ADDRES		CILITY			Tuge			
	1/2/							Funera						
\dashv	23. PART i. Enter the diseases, or o	omplications the	t caused the de	ath. Do r	1 426	Jover	Str	eet. F	asto	n. N	lary1	Approximate		
	shock, Dr heart fallure.	List only one cau	aa Dn each iina	,			·g, uco	r ao caraigo	от гозра	actory on	rout,	interval Between		
	IMMEDIATE CAUSE (Finel disease or condition	Coll	Witis	C	elluliti	c						Onset and Death		
	resulting in death) a. CELLULITIS TWO WEED DUE TO (OR AS A CONSEQUENCE OF):													
z		h. '												
을 II	Sequentially list conditions, if any, leeding to immediate	DUE TO	(OR AS A CONSEC	DUENCE D	F):									
2	CAUSE (Disease or injury	c												
	that initiated events resulting in deeth) LAST	DUE 10	(OR AS A CONSEC	DUENCE O	F):							i 1		
CERTIFICATION		đ												
A.	PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY ENDINGS PERFORMED? AMAILABLE PRIOR TO													
DICAL								_ 10	YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME										1		1 TES 2 NO		
	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S NO [UNCE	RTAIN	10						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check only one) OTHER:									
YSI	1 - YES 2 NO	10 Inpatient 2		□ DOA	4 Nursing Hon	e 5 🗆 Res	Idenca	6 🗆 Other (Sp	ecify)					
표	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, De		28b. TIM INJ		URY AT		28d. DESCRIE	BE HOW IN	JURY OC	CURED			
B	2 Accident Investigation	20- 01 405 01	E IN HARRY			YES 2	NO							
	3 Suicide a Could not be 4 Homicide determined	building,	etc. (Specify)	me, farm, s	street, lactory, offic			281. LOCATIO City or To		nd Numbe	r or Rurel R	oute Number,		
COMPLETED	29a, CERTIFIER													
₩ I	(Check only													
8	2 MEDICAL EXAMINE		temination and/or i	nvestigatio	n, in my opinion, o	eath occurs	d at the t	time, data and	place, end	d dua to t	he cause(s)	and manner as stated.		
88	296. SIGNATURE AND TITLE OF CERTIFIER	<u>}</u>				29c. LICEN	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)		
0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED OFFI	E OF BEATURE	4.070.77	D-1-m	01	17	<i>t1.</i>		7 7	-/14/	195		
	Vinodrai Mehta,	M.D.			Street		Camb	ridge	МП	214	613			
ŀ	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE		- DELCEL		Jaill	rage	, riii	410	012			
	FEB 1 7 1995	61. M	widen Ran	LA										
il.	CEDI/BINA	Little of the	THE PERSON NAMED IN											

10377 1886 Selection

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/15/95 t.t 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

		1. DECEDENT'S NAME (FIR	st, Middle, Last)	C	ARLOS	Н	ARMO	N	JR.		MONTH		DAY	YEAR	3. TIME OF DEATH	-
		4. SOCIAL SECURITY NUM	IBER	5. SEX	6. AGE (In yr	s. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS	7. DATE (RCH_	0.5	9.5 8. BIRTH	PLACE (State or Foreign	IN
		212-04-8446 12 M 2		1 M 2 - F	26	YRS.	MONTHS	DAYE	HOURS	MIN.	(Month,	Day, Year)	8	Countr	MD	
3 should		9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA												_		
2, 3	O.B.	2519 ORLI		STREET				BAL	TIMO	DRE (CITY	_				
- L SS - T		RESIDENCE OF DE	10b. COUNT	Υ		10c CIT	Y, TOWN C	NR LOCAT	TION!					T		_
2	DIRECTOR	MD					, , , , , ,			e Ci	+				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
permit. Pages 1,	A A	10a. STREET AND NUMBE	R		***				ZIP CODE		СУ	_	10g. CIT	ZEN OF W	HAT COUNTRY?	_
75	<u> </u>	2519 Orle	ans St	•					2122	24			Ш	S.A.		
_AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Div		12. WAS DECEDER FORCES? 1 IF YES, GIVE V	YES 2	NO		If yes, sp	ENDENT OF	F HISPANIC n, Maxican, Specify:	ORIGIN? Puerto R	(Specify can, etc.)		14. RACE Black	— American Indian, , Whita, atc. by: 11 te	
N 5 8	8	15. DE	CEDENT'S EDU	CATION	164	. DECEDENT'S	USUAL OC	CCUPATIO	ON		16b.	KIND OF E	BUSINESS/INC		Tre	_
2121 al or atter for use a	once. COMPLETED	Elementary/Secondary	nly highest grade (0-12)	College (1-4 or 5	+)	(Give kind of work done during most of working life. Do NOT use refred.)										
ND ched	MP	Unk.		Unk.		Neve	er En	plo	yed							
the h	COM	17. FATHER'S NAME (First,							18. MOTH	ER'S NAME	(First, M.	ddle, Maid	en Sumame)			_
MARYL retained by 5 should be	ed at	James C.		Sr.		,				ice (
MARYLAND 2121 retained by the hospital or att 5 should be detached for use	TO B	James Har				19b. MAILING								Code)		
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certificate be executing physician and Hygiene prior to bur	or other traumatic	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):														
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12. REGISTRARYS SIGNAPURE

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MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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31. DATE FILED (Month, Day, WAR 03

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Fig. 6 may be retained by the hospital or attending physician. funeral director, å ysician and completely filled in by prior to burial, cremation, or remosigned by the attending physician Health and Mental Hygiene prior to DIRECTOR; After this certificate has been hours after death with the State Dept. of DR ATTENDING PHYSICIAN: The law TO THE FUNERAL De filed within 72 h TO THE P

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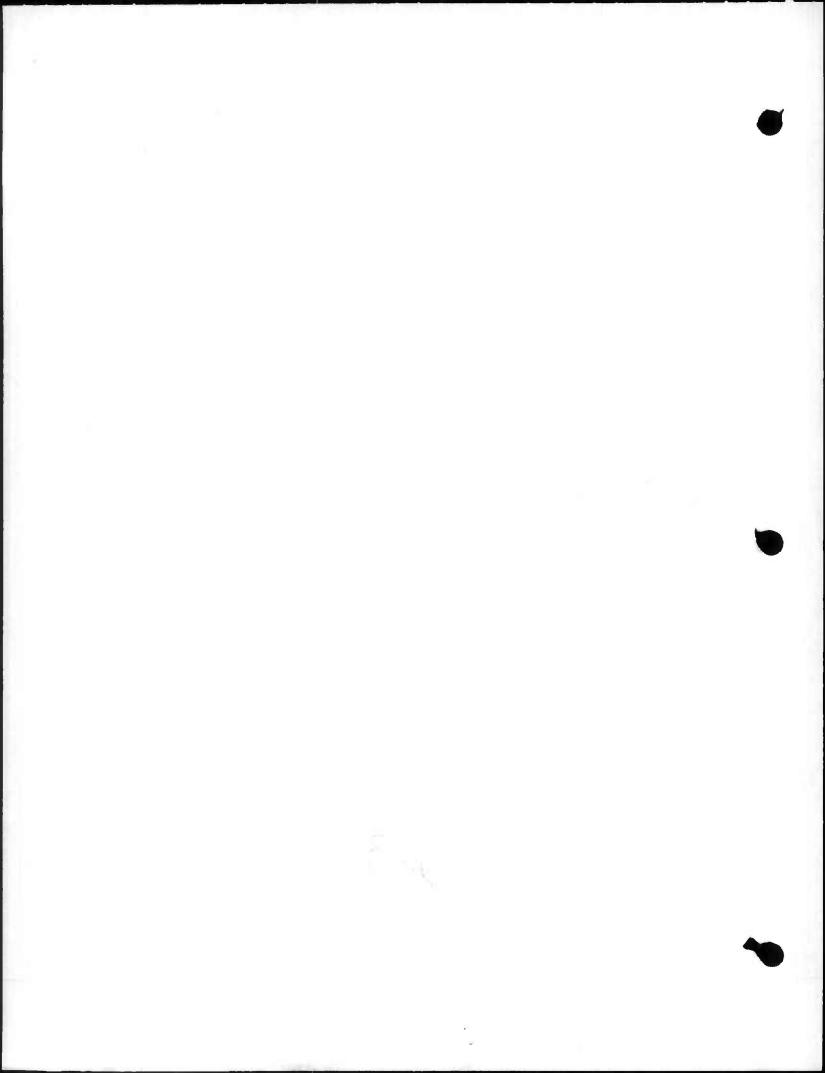
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Margaret Kinder Hobbs 2. DATE OF DEATH 3. TIME OF DEATH Margaret K. Hobbs February 1995 6:03 am 28, 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs, last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) DAYS 1 M 2 X I YRS. 578-32-0457 Sept. 19, 1909 South Carolina 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY IDE. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 810 Brice Road 20852 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TYES 2 X NO BY Specify: Specify: 3X Widowed 4 Divorced White 9 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) ᇤ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Post Office Accountant Government 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Sumerne) John Kinder BE Minnie Meadows 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Oda Melton Hobbs 810 Brice Road, Rockville, Maryland 20852 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) March 2, 1995 20c. LOCATION - City or Town, State Buriel 2 Cremation 3 Re cemetery, cremetory or other place) March Parklawn Memorial Park ■ □ Donation 5 □ Other (Specify) _ Rockville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rockville, Inc. 300 West Montgomery Avenue M00831 Barbara go mon dawrence Rockville, Maryland 20850 23. PART I. Enter the diseases, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory street, **Approximate** shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death diseese or condition eumonia reauiting in death) DUE TO (OR AS A CONSEQUENCE OF) ablactive Pulmoray Mean CERTIFICATION Sequentielly ilst conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 M Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 XNO ng Nome 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 1XXNatural м 1 YES 2 NO BY 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide 29a. CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner se stated. 2 ___ MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner es stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 8 29d. DATE SIGNED (Month, Day, Year)

020518

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February 28,1995



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE

	REGISTRAR		CERTIFI	CATE OF	DEATH	REC	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE.	ATH DAY	YEAR	3. TIME OF DEATH		
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	a contract was produced		(In yrs. lest birthdey)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day, 1) FEB. 27	Mar)	Count			
	- 10 0 1 - 100		87 YRS.			_					
œ	9a. FACILITY NAME (If not institution, give street				OR LOCATION OF D						
DIRECTOR	HEBREW HOME OF GRE	ATER WASHI	NGTON		ROCKVILL	E	MOI	NTGO	1ERY		
<u> </u>	10a. STATE 10b. COUNTY		10c. CfT)	, TOWN OR LOC	ATION				10d. INSIDE CITY		
듬	MARYLAND MONTG	OMERY	R	OCKVILI	E		LIMITS?				
AL	10e. STREET AND NUMBER		-	1	Of. ZIP CODE		10g. CIT	IZEN OF V	WHAT COUNTRY?		
FUNERAL	6121 MONTROSE ROAD				20852		UN	LTED	STATES		
5		. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED		CENDENT OF HISPA			14. RACI	IACE — American Indian, Black, White, etc.		
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR			S 2 X NO Speci		HC.)	Spec			
	15. DECEDENT'S EDUCAT		1	1					WHITE		
=	(Specify only highest grade con	npleted)	18a. OECEDENT'S (Give kind of w life. Do NOT us	vork done during n	ION nost of working	16b. KIND	OF BUSINESS/IN	DUSTRY			
2	Elementary/Secondary (0-12)	College (1-4 or 5+)		EMAKER			OWN HOL	ME.			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1011		18 MOTHER'S NA	AME (First, Middle, I					
	ESOX POPOK				MAR		STEIN				
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural			io Code)			
5	THEODORE HYMAN (SO	N)							NG, MD 20906		
	20a. METNOD OF DISPOSITION	20	b. PLACEAND DATEC	F DISPOSITION (Name of		Oc. LOCATION -				
	1 X Buriel 2 Cremetion 3 X Remove 4 Donation S Dutter (Specify)	from State	BROTHERS	OF ISR	AEL				NCH, N.J.		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	sen ()		22 NAME	ND ADDRESS OF F				PELS, INC.		
	· 41.	to M			ROCKVILL						
	23. PART i. Enter the diseases or con	polications that cause	d the death Do n								
	shock, or heert failure. Lis	t only one ceuse on	each line.	or enter the m	ode or dying, aut	m ae cerdiec or	reapiratory ar	rest,	Approximate interval Between		
	immediate cause (Fine) disease or condition ALZHEIMERS DISEASE 12 YEARS										
	ALZHEIMERS DISEASE DUE TO (OR AS A CONSEQUENCE OF): 12 YEARS										
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<u>ا</u> ق	Sequentielly list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	CAUSE (Disease or injury										
<u> </u>	that initieted events	OUE TO (OR AS	A CONSEQUENCE OF	7):							
ᇤᅵ	resulting in deeth) LAST										
	PART ii. Other significent conditions of	ontributing to deeth	but not regulting i	n the underlyi	na ceuse aiven in	Pert I 24a V	WAS AN AUTOPSY	246	WEDE ALTTOREY EINDINGS		
₹	HYPERTENSION, HEAD				ag could given in	Р	ERFORMED?	ERFORMED? AVAILABLE PRIOR TO			
EDICAL	HIP DECUBITUS	DECOIL				— ¹ 🗆 ¹	YES 2 NO		OF OEATN?		
Σ	HIP DECUBITUS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	TTIMEDOTE TO	CAUGE OF			-					
딣	EXAMINER?	OSPITAL:	uniform a 🗆 Box		me 5 Residence						
۲ ۲	27. MANNER OF DEATN	Inpetient 2 ER/Out	28b, TIMI		me 5 Rasidence		NOW INJURY OC	~ IDEA			
	1 X Natural 5 Pending	(Month, Day, Year)		URY W	YES 2 NO	zed. DESCHIBE	NOW INJUNT OC	COREO			
В	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJUR	Y — At home, farm, s			28f. LOCATION	(Street and Numbe	er or Rumal I	Route Number		
	4 Nomicide 6 Could not be determined	building, etc. (Spe	ecity)			City or Town					
<u> </u>	29a. CERTIFIER (Check only 1 X CERTIFYING PNYSICIA	N: To the heat of our beau				II Valoreassa II. sa	Se oscilles do	= 4			
COMPLETED	Account to the contract of the	On the bests of examination							and manner as stated		
	THE STATE OF THE S	</td <td></td> <td></td> <td>_</td> <td></td> <td></td> <td></td> <td></td>			_						
띪	11110	4		with	29c. LICENSE NU D 0588.				(Month, Day, Year) ARY 26, 1995		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE DE O	FATH (ITEM 27) /Fine	Print	1 - 5500		1				
	STEVEN LIPSON, M.D				KVILLE.	MARYT.ANT	20852	2			
	31. DATE FILEMAR "02" 1995	32 AEGISTAAR'S SIG					20032				
	MAK UL 1995	Julia d'auch	corpordall								

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within anounts after or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 Is marked, or item 23 shows any Injury, or other traumatic event, the medical e
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ended # 8 # 17 # 96 2/28/95 MRT STATE OF MARYLAND I DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2 DATE OF DEATH 23,1995 ≝February Dolat M. Hajiyani 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. RIRTHPLACE (State or Foreign 1 M 2 XX 560-78-4111 February 13,1934 Bombasy, India 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Rockiville Shady Grove Adventist Hospital Montgomery 10e. STATE 10c, CITY, TOWN OR LOCATION Montgomery Rockville Maryland 10e. STREET AND NUMBER og CITIZEN OF WHAT COUNTRY? United States 10f. ZIP CODE 1420 Gerard Street 20850 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cuben, Mexican, Puerto Ricen, etc.) RACE — American Indian, Black, White, etc. 1 Never Merried 2 XX Ferried IF YES, GIVE WAR OR DATES 1 TES ZX NO Specify: 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 12 3 Data Processing Private 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sakina Badamia S. Ajkani Yusuf 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mehdi H. Hajiyani same as #10 20e. METHOD OF DISPOSITION
1 Seriel 2 Cremetion 3 Removal from State
4 Disposition 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE George Washington Cemetery Feb. 26, 1995 Adelphi, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) -ongestine DUE TO (OR AS A CONSEQUENCE OF): Bronan Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🖾 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:

1 YES 2 NO 1 YES 2 NO 1 9 Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Matural 5 Pending 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide

29e CERTIFIER t DCCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.

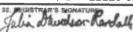
2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(e) end menner ee stated.

29b. SIGNATURE AND/TUILE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) anna 39671 FEBRUARY 23 1985

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

11120 New Hampshire Avenue, #100 Silver Spring, Maryland 20904

31. DATE FILED (Month, Day, Year) 1995



3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

Specify: White

XX YES 2 NO

Approximate

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

COMPLETION OF CAUSE OF DEATH?

Interval Between

Onset and Death

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending ph	ER/	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF BEATH Kar 9 23 Stanley 2 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTHPLACE (State OCT. I, 127-30-6025 1 X M 2 1 55 YRS YORK 1939 NEW 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY GAITHERSBURG 1 TYES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20117 HOB HILL WAY 20879 UNITED STATES 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

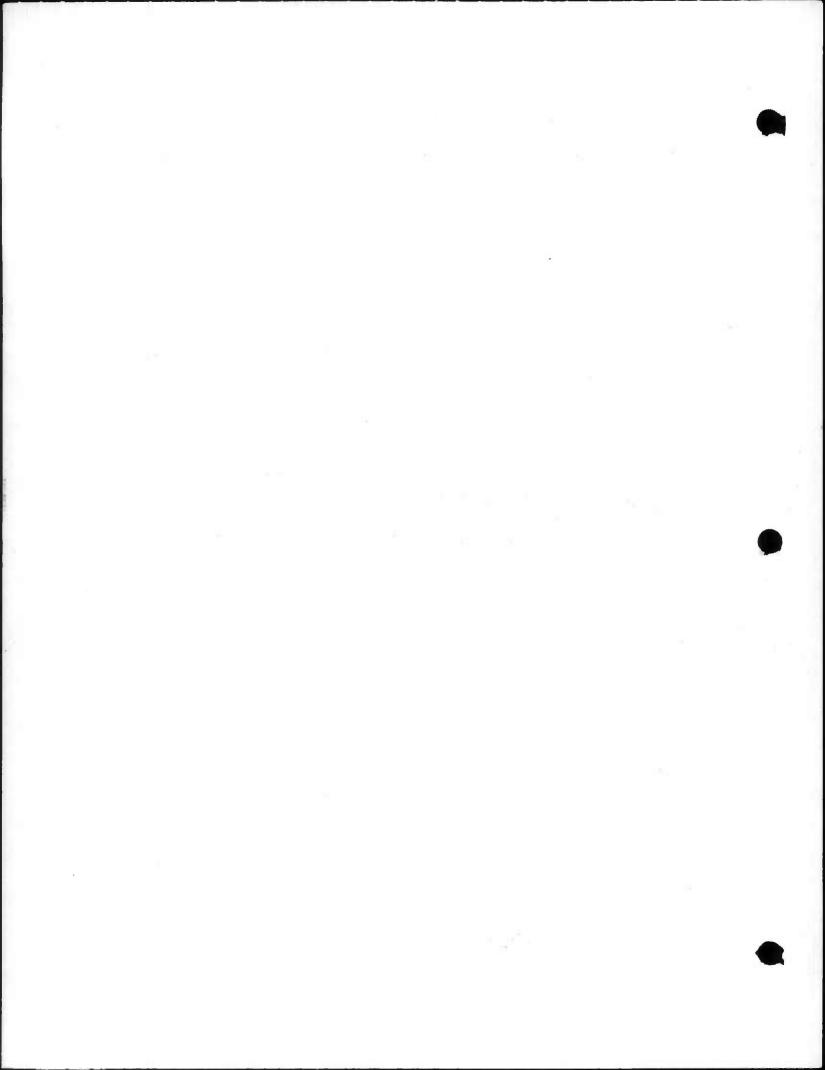
1 YES 2 NO Specify: 1 Never Married 2 Merried Specify: WHITE BY 3 Wildowed 4 X Divorced 16a. DECEDENT'S USUAL OCCUPATION
170 kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) SYSTEMS ANALYST FEDERAL GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surneme HARRY notified at HENDLER BE BEATRICE RATNER 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SHARA HENDLER (DAUGHTER) 5107 BROOKEWAY DRIVE, BETHESDA, MD 20816 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State **Hust** MT. COMFORT CREMATORY 2/28 ALEXANDRIA, VIRGINIA 21. SIGNATURE OF PUNERAL SERVICE LIGHNSEE examiner 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Jake 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart fallure. List only one cause on each line. Approximata intervai Between IMMEDIATE CAUSE (Final **Onset and Death** å. Edoma disease or condition Acute ulmondh hours resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) 5 89 Se erman part traumatic CERTIFICATION Sequentielly ilst conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata Screre cause. Enter UNDERLYING CAUSE (Disease or Injury 9 26012 other DUE TO (OR AS A CONSEQUENCE OF). thet initiated events resulting in death) LAST 6 injury, PART ii. Other aignificant conditions contributing to deeth but not recuiting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 - YES 2 1 NO OF DEATH? Shows 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) item **EXAMINER?** HOSPITAL: OTHER: 1 - YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Residence 6 - Other (Specify) 5 27. MANNER OF OEATH 26e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO M BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 80 3 Sulcide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 | Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner as stated. (Check only one) MEDICAL EXAMINER: On the basis of examination investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner as stated. 190 SEMATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day, Year) BE Leway 2/20/ 91 808 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)

31. DATE FILED (Month, Day, Year)

1995

32, REGISTRAR'S SIGNATURE

Muchan Rayfull



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician.

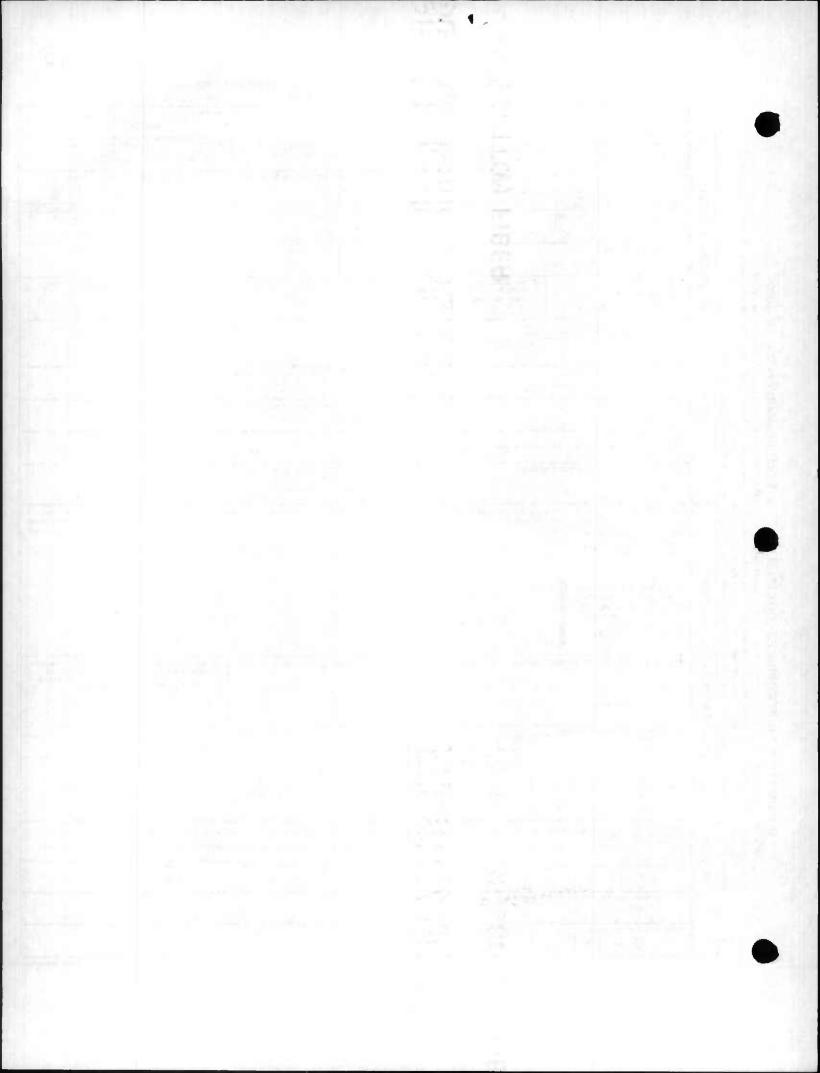
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at nace. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		CERTIF	ICATE OF DE	ATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) John Paul Henni					March 2	1995	3. TIME OF DEATH 3: 45 P
	4. SOCIAL SECURITY NUMBER	5. SEX (. AGE (in yrs. last birthday)	IF UNDER 1 YEAR IF U	NOER 24 HRS. 7.	DATE OF BIRTH		RTHPLACE (State or Foreign
	216-18-3545	1 XM 2 🗆 F	71 YRS.	MONTHS DAYS HOU	RS MIN.	Nov 13, 1	923 Ma	aryland
	9e. FACILITY NAME (If not institution, give	street and number)		96. CITY, TOWN OR LO			9c. COUNTY OF	-
H	Howard County G	eneral	100 per 1	Columbia			Howa	ard
15	RESIDENCE OF DECEDENT	31.02.02		COTARDIA			11000	<u>u.u</u>
DIRECTOR	10e. STATE 10b. COUNT	TY		Y, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?
		ward_		Ellicott C	ity			1 TYES 2 NO
4	10e. STREET AND NUMBER		153000	10f, ZIP (CODE		10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL	2518 Jonathan Ro	oad		21	042		Unite	ed States
5	11. MARITAL STATUS		EVER IN U.S. ARMED			ORIGIN? (Specify Yes	or No- 14. R/	ACE — American Indian, lack, White, etc.
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAY	OR DATES	1 TES 2 M		derio ricini, atc.)		White
ED	15. DECEDENT'S ED			USUAL OCCUPATION		16b. KIND OF BUS	BINESS/INDUSTRY	
Li.	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT us		rorking			
I de		2	Indust	rial Sales		Yale Fo	rklift	Company
COMPLETE	17. FATHER'S NAME (First, Middle, Last)			10. 0		(First, Middle, Meiden		
BE	John P. Henning	Sr.			Violet	Bre	wster	
TO E	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street and Nu				
-	Agnes M. Henning		2518	Jonathan R	oad EII.	icott Cit	y, MD 2	21042
	20g. METHOD OF DISPOSITION 1 ABurtal 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	noval from State	20b. PLACE AND DATE (cornetery, cremetory or o Crestlawn		-	ch 6 Mar		rille, MD
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE		22. NAME AND AD	DRESS OF FACILI	Funeral	HOmo In	00
	1 Stale	-/-		4112 01	d Columi	hia Pike	Ellicot	t City 21043
	23. PART I. Enter the diseases, or	complications that	caused the death. Do i					Approximeta
	shock, or heart failure	List only one ceus	on each line.					Interval Between Onset and Death
	disease or condition	Vantain	Par must	lineurs 20	(O) In	Kelen	CARDIN	1991
	resulting in desth)	DUE TO (C	IR AS A CONSEQUENCE OF	COVIEWS ()	10	130	0 101/01	00,000
z		h						I
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (C	R AS A CONSEQUENCE O	F):				
ঠ	cause. Enter UNDERLYING CAUSE (Disease or Injury	с						
E	that initiated events resulting in death) LAST	DUE TO (C	R AS A CONSEQUENCE O	F):				
H	3	d						
	PART II. Other significent condition	ns contributing to d	eath but not resulting	in the underlying cau	se given in Par	rt I. 24e. WAS AN		24b. WERE AUTOPSY FINDINGS
EDICAL	HIM per I new	live				PERFOR	\7	AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 VES 2	A NO	OF DEATH?
Σ								1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. PLACE C	DE DEATN (Check	only one)		
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3 DOA	OTHER:	Residence 6			
¥	27. MANNER OF DEATH	28e. DATE OF III	IJURY 28b, TIM	E OF 28c, INJURY A	-	d. DESCRIBE NOW II	NJURY OCCURED	
	1 Natural 5 Pending	(Month, Day	Year) INJ	M 1 YES				
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	INJURY — At home, farm,	street, factory, office	26	II. LOCATION (Street o	and Number or Run	al Route Number,
	4 Nomicide determined	building, et	c. (Specify)			City or Town, State)		
	290. CERTIFIER	EICIAN: To the heet of a	y knowledge, death occurr					
	(Check only	STORTE SOLE OF THE						
MP	000)	ER: On the basis of exa	mination englor investigatio			at mana anna bimont an		hatels are manner as stated
COMPLETED	one) 2 MEDICAL EXAMIN		ministion end/or investigation					e(e) end menner ee stated.
BE COMP	000)		mination end/or investigation		LICENSE NUMBE			(e) end menner ee stated.
ш	2 MEDICAL EXAMIN	illa		290				
BE	29b. BIGNATURE AND TOTE OF CERTIFIE	illa		Print)	1348	18	29d, DATE SIGN	
BE	2 MEDICAL EXAMIN	illa	OF DEATH (ITEM 27) (Typo	290	1348	18		



Amended I tem#206 3/3/95. S. CAmpbell
CARROLL COUNTY

07846

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIFIC	CATE OF DEATH	REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
Anna P.	Humph	ress		Month DAY March 1	1995	4:40 P M
4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR IF UNDER 24 HRS.	7 DATE OF BIRTH	0.00	IRTHPLACE (State or Foreign
217-28-0841	1 M 2 TF	93 YRS.	ONTHS DAYS HOURS MIN.	(Month, Day, Year) 10/19/19	01 6	ountry)
9e. FACILITY NAME (If not institution, give s	Λ		Db. CITY, TOWN OR LOCATION OF DE		9c. COUNTY O	ermany
	,			EATH		
Frederick Vil:	la Nursir	ig Home	Catonsville		Balt	imore
10e. STATE 10b. COUNT	Υ	10c. CITY.	TOWN OR LOCATION			10d, INSIDE CITY
Maryland Car	1 1	100				LIMITS?
Maryland Cari	1011	wes	tminster			1 TES 2 NO
			10f. ZIP CODE			OF WHAT COUNTRY?
344 Barnes Ave			21157			ed States
11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT ET	VER IN U.S. ARMED	13. WAS DECENDENT OF HISPAN If yee, specify Cuben, Mexico	IC ORIGIN? (Specify Yes of	or No- 14. R	IACE — American Indian, Black, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	1 TYES 2 NO Specific		1	Specify:
21			1			white
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S US (Give kind of woo	SUAL OCCUPATION rk done during most of working retired.)	16b. KIND OF BUSII	NESS/INDUSTR	ry .
Elementery/Secondery (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)			
8		Homema	ker	n/a		
17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Malden Si	urname)	
Joseph	Stracke		There	se	Faus	t
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DORESS (Street end Number or Rural	Route Number, City or Town,	State, Zip Code)
Anna J. Currar	3	344 B	arnes Avenua	. Westmin:	ster.	MD 21157
20e. METHOD OF DISPOSITION		20b. PLACE AND DATE OF			ATION City o	
1 XBurlel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)	ovel from State	cometery cremetory or other	r nlecel	1///		
21. SIGNATURE OF FUNERAL SERVICE LIC	TENCEE	New Cathe	dral Cemeter	y 3/4/4h Ba	ltimo	re, MD
The state of the state service ex	JENGEE		Pritts Fun		& Ch	anal
Katheria P	with - New	iter				minster, MD
23. PART I. Enter the diseeses, or	complications that co	nused the deeth. Do no	t enter the mode of dving, auc	h as cardiec or respire	tory arrest.	Approximate
ahock, or heert feilure.	List only one cause	on eech line.				interval Between
iMMEDIATE CAUSE (Finel disease or condition	1	1-0. A	h			Onset and Death
resulting in death)	a	Spralien	Preumon	2		days
	DUE TO (OR	AS A CONSEQUENCE OF):	V	Λ		
Sequentially list conditions,	b	elebrovas	preumonicular accid	lent		2-3 weeks
if any, leading to immediate	DUE TO (OR	AS A CONSEQUENCE OF):				
CAUSE (Disease or Injury	Ç					
that initieted events	DUE TO (OR	AS A CONSEQUENCE OF):				
resulting in deeth) LAST	d					
PART II Other significant and date		- Ab - A				
PART ii. Other significant condition	a contributing to de-	eth but not resulting in	the underlying ceuse given in	Part I. 24s. WAS AN A PERFORM		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
				1 TES 2	NO	COMPLETION OF CAUSE OF DEATH?
					`	1 TYES 2 NO
DID TOBACCO USE	CONTRIBUTE 1	O CAUSE OF	DEATH YES NO	X		
25. WAS CASE REFERRED TO MEDICAL			28. PLACE OF DEATH (Ch	eck only one)		
EXAMINER?	HOSPITAL:	R/Outpatient 3 DOA 4	THER:	8 Other (Specific)		
27. MANNER OF DEATH	28e. DATE OF INJ	URY 28b. TIME	OF 28c, INJURY AT	28d. DESCRIBE HOW IN.	JURY OCCURE	,
1 Natural 5 Pending	(Month, Day,		WORK? M 1 YES 2 NO	and begoings from the	JOHN COCONE	1
2 Accident Investigation	20- 01 405 05 11	Lattery A. S.				
3 Suicide a Could not be 4 Homicide datermined	building, atc.	IJURY — At home, farm, str. . (Specify)	eet, factory, offica	28f. LOCATION (Street en City or Town, State)	d Number or Ru	iral Route Number,
- Individue Gatarining						
29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my	knowledge, death occurred	at the time, date and place, end due	to the cause(e) end mann	er se stated.	
and the second s			in my opinion, death occured at the			se(s) and manner as stated.
296. SIGNATURE AND TITLE/OF CENTIFIE	- h - /	1				(C.171
2011 SIGNATURE AND TITLE OF CENTRE	"Irku	D	29¢. LICENSE NUI	MEN	26d, DATE SIGN	NED (Month: Day, Year)
gas			23	6130	31	1195
30. NAME AND ADDRESS OF PERSON WH		OF DEATH (ITEM 27) (Type, P	rint)	11 - 0 .	(.	10 X 7 1 7 0 1
10041	ch mis &	21 NEW	aw st, suite	40/ Dal	nmole	MD 21201.
31. DATE FILED (Month, Day, Year)						
authorities .	32. REGISTRAR'S					
WAK 02 1995 July	32. REGISTRAR'S					

ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

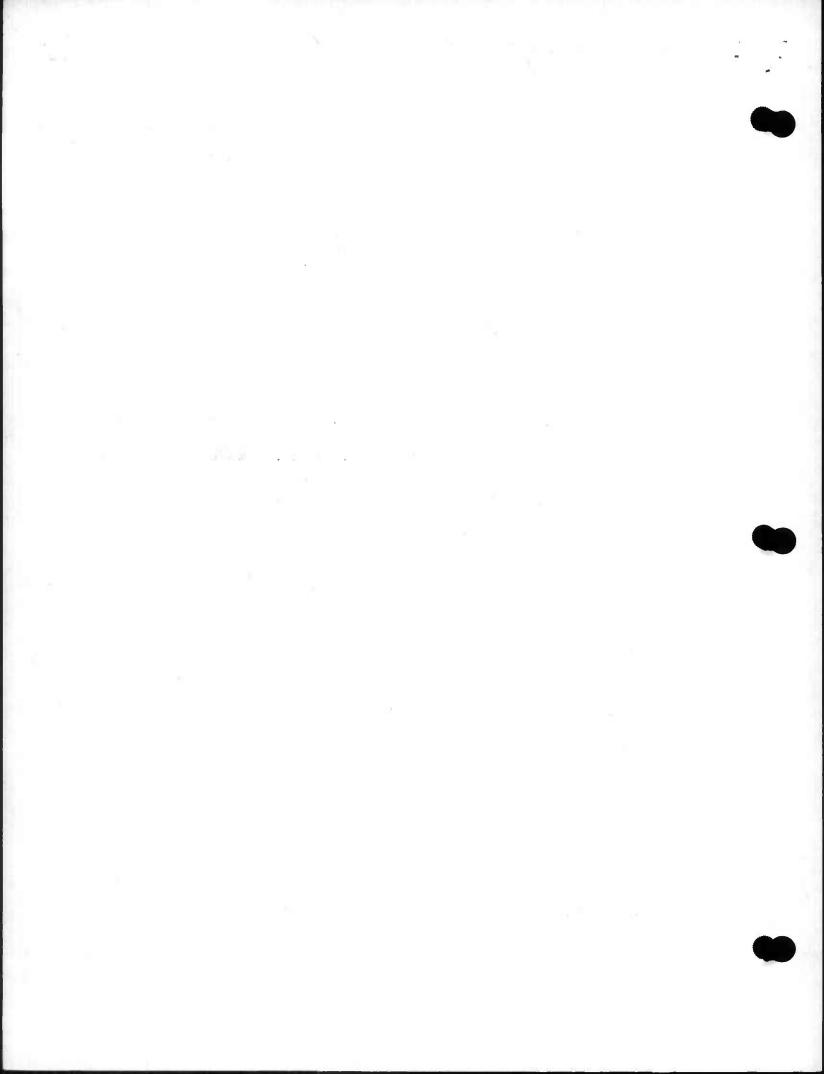
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760.

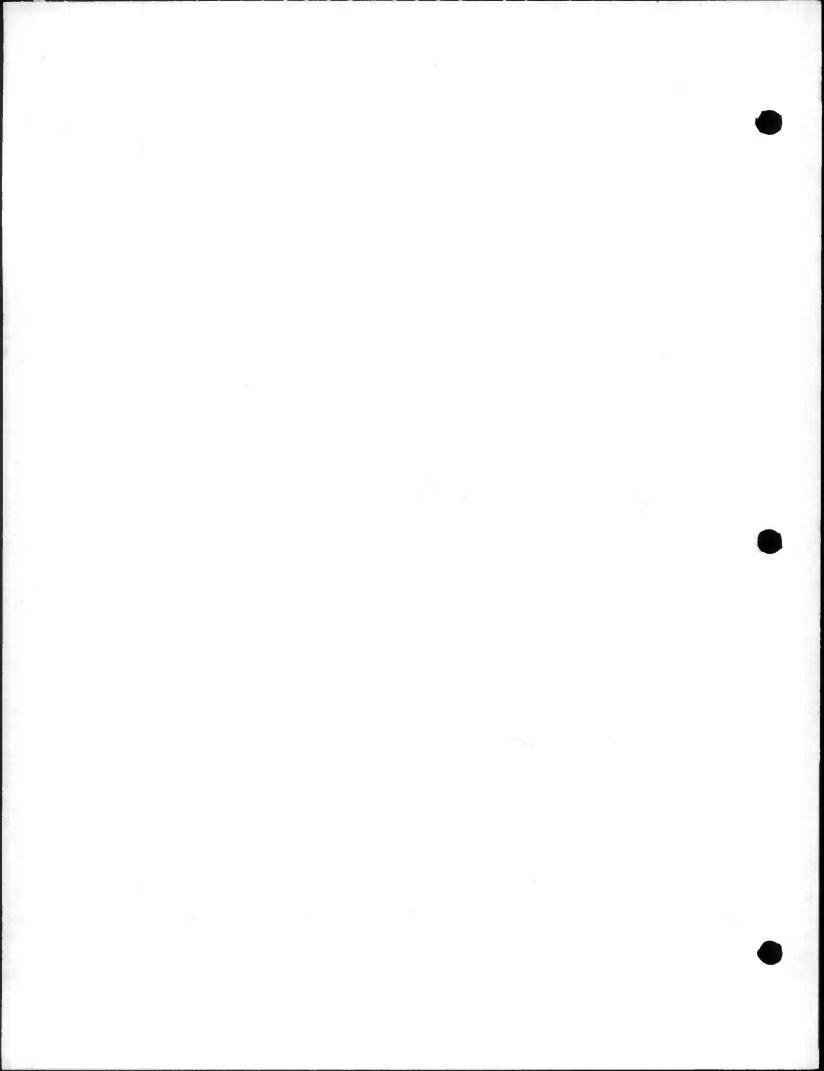
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH FEBRUARY 22, LELA ANN HAWSE 1995 11:35 A M 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Aug 31, 1 M 2 DF 217-10-1017 1920 WV permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SACRED HEART HOSPITAL CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Allegany Cumberland TYPES 2 NO 10e. STREET AND NUMBER FUNERAL INC. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA use as the burial-transit 121 Grand Avenue 21502 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: white COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) funeral director, page 5 should be detached for College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Somers Slaubaugh Iva Mae (Wotring) notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Donna J. Fisher 3215 Taylor Avenue; Baltimore, MD 21234 death. Page 6 may be pe 20a. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremelion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must OATE 02/25 Cumberland, MD 4 Donation 5 Other (Specify) Hillcrest Burial Park examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY Scarpelli Funeral Home anes Cumberland, MD 21502 been signed by the attending physician and completely filled in by the r. of Health and Mental Hyglene prior to burial, cremation, or removal. hours after the medical 23. PART I/Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or haert fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finei Onset end Daath disease or condition ____ ei leave Alule DUE TO (OR AS A CONSEQUENCE OF): 26 de event, COPZ traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate 2.147 cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24e. WAS AN AUTOPSY PERFORMED? any 1 YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\boxed{D}\) PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate I HOSPITAL: OTHER: 1 TYES 2 THO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) this c. 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident Investigation 3 Suicide 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town. State) 99 8 Could not be COMPLETED 28 4 Homicide S 29a. CERTIFIER 11 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. FUNERAL (within 72 h TANT: If II TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 290 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER 837 cereced U 00 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. URIEL VELANDIA, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502 31. DATE FILED (Month, Day, Year) FEB 2 8 1995 32. REGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

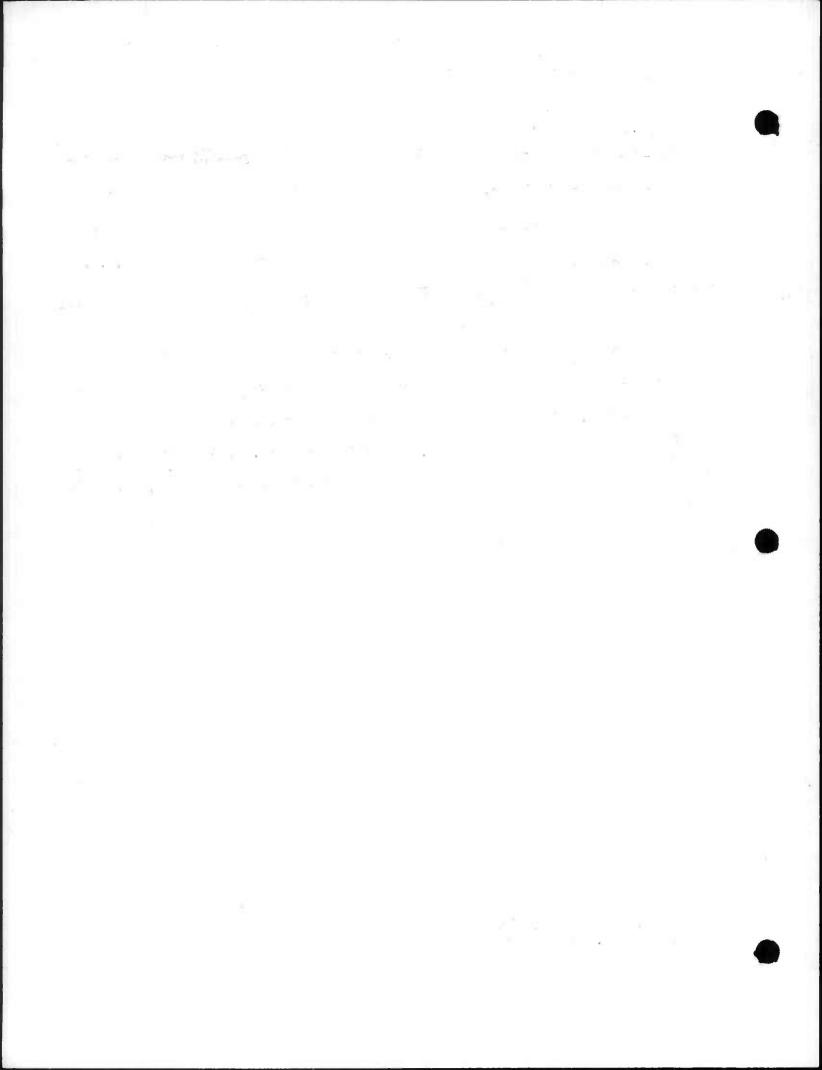
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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	NEGIO I NAN		CI	-DILL	ICAIL	UF	DEA	П		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last, Howard	T.	Hanna						2. DATE MONTH	25,	1995	YEAR	3. TIME OF DEATH 12:15 a m
	4. SOCIAL SECURITY NUMBER 217-28-0568	5. SEX	8. AGE (In yrs. les	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	MIN.	(Month	Dey, Year)	200	Countr	
1	9e. FACILITY NAME (If not institution, give	street and number			Oh CITY	TOWN	0010017	ON OF DE		16 19		MTY OF D	ryland
OB	Frostburg Hospi	,			90. C/11		rostl		EAIH		9c. COUI		egany
5												Samuel C	- E carry
DIRECTOR		llegany	10c, CIT	Y, TOWN C	OR LOCAT		stbur	rg				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 82 Broadway					101	. ZIP COD	£ 21532	2		10g. CITI		VHAT COUNTRY?
Z	11. MARITAL STATUS	12. WAS DECEDENT	T EVED IN II C. AD	MED	140.1								
BY	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 -A	Ю		If yes, spi	ecify Cubi	Specify	n, Puerto R	(Specify Yes ican, etc.)	or No—	14. RACE Black Speci	E — American Indian, t, White, atc. fy: White
8	15. DECEDENT'S ED	UCATION	16e. DE	CEDENT'S	USUAL O	CCUPATIO	ON		16h	KIND OF BUS	INESS/IND	HISTOV	HILLOG
E	(Specify only highest grad Elementary/Secondary (6-12)		(Gi	Do NOT us	work done o	during mo	st of worki	ng	1.02.	0, 200	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7031111	
COMPLETED	10	Cotlege (1-4 or 5+		Vev er	wor	ked				N	one		
	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, M	iddle, Meiden	Sumame)		
BE	Ulysses		Har					lary					liams
2	19e. INFORMANT'S NAME (Type/Print)		4							er, City or Town			
-	Margaret H. Wal				oadw			stbu	irg,	Maryla	nd	2153	2
	20a METHOD OF DISPOSITION 14 Burlel 2 Cremetion 3 Rer 4 Donation 6 Other (Specify)	noval from State	cemetery, crei	mataniara	ther place!			Feb.	1	20c. LOC			wn, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEL	/	a g O L a G	22.1	NAME AN	D ADDRE	SS OF FAC	CILITY	Durst	Funo	nol.	Har y Land
Ш	> John 7	Alur	4		5	7 Fr	ost	Aven	nue F	rostbu	rg,	Md.	
	23. PARY . Enter the diseases, or	complications thet	caused the da	eth. Do r	ot anter	tha mo	da of dy	Ing, aucl	h aa cardi	ac or respir	atory arr	eat,	Approximata
	ahock, or haart fallure.	7											Interval Batween Onset and Death
	disease or condition	Dulm	onati	J	Om	ha	lich						716+5
	reaulting in death)	a. DUE TO	OR AS A CONSEC	UENCE OI	F):	1	1.711	-					93110
2		OXOUIN	OR AS A CONSECUTION OF AS A CONSECUTION OF A CONSECUTION	U U	PIN	+61	rom	1151	151+	100			DULS
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate	OUE TO	OR AS A CONSEC	NENCE OF	ŋ:	7.		700		1			10/10
2	CAUSE (Disease or injury	c											
분	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEC	UENCE OF	F):								
5		d											
	PART II. Other significent condition	ns contributing to	deeth but not n	esulting i	n the un	derlying	Cause /	niven in	Part i	24e. WAS AN	HITODEY	245	WERE AUTOPSY FINDINGS
EDICAL		steen.	dispas	4			, cadeo ;	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rait i.	PERFOR		240.	AVAILABLE PRIOR TO
ā	Corsinity	a city	011010	/ _			-		— I	1 TES 2	LNO		COMPLETION OF CAUSE DF DEATH?
Σ							/					1	1 TYES 2 NO
SICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAL					UNC	ERTAIN	4 🗆			1	
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	/ 26. PLAC	E OF DEAT	H (Check o								
S	1 DES 2 NO	1 - Inpatient 2	ER/Outpatient 3	□ DOA	OTHER		5 🗆 Re	eldence	6 🗆 Other	(Specify)			
Y PHY	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF (Month, Da		28b, TIM	E OF URY M	28c. INJI WOI	URY AT RK? 'ES 2	NO	28d. DESC	RIBE HOW IN	JURY OCC	CURED	
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF building, a	FINJURY — At hor	ne, ferm, s	treet, facto					TION (Street or Town, State)	nd Number	or Rural A	oute Number,
COMPLET	(Check only 000) 2 MEDICAL EXAMIN												end menner ee stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	R			**		29c. LICE	NSE NUM	IBER		29d. DATE	SIGNED	(Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON W	O COMPLETED CAUS	E OF DEATH (ITEM	27) (Type,	Print)		1)0	70	31		0	16	45
	DONALD F.M	ANGEL	R+2	130)		8 (Chw	P)CH	land	Ma	21	50)	
	31. DATE FILED (Month, Day, Year) FFB 2 7 19	OK SPREGISTRA	'S SIGNATURE	dall									
. 10	FED 2 / 13	33 /	140275					_					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

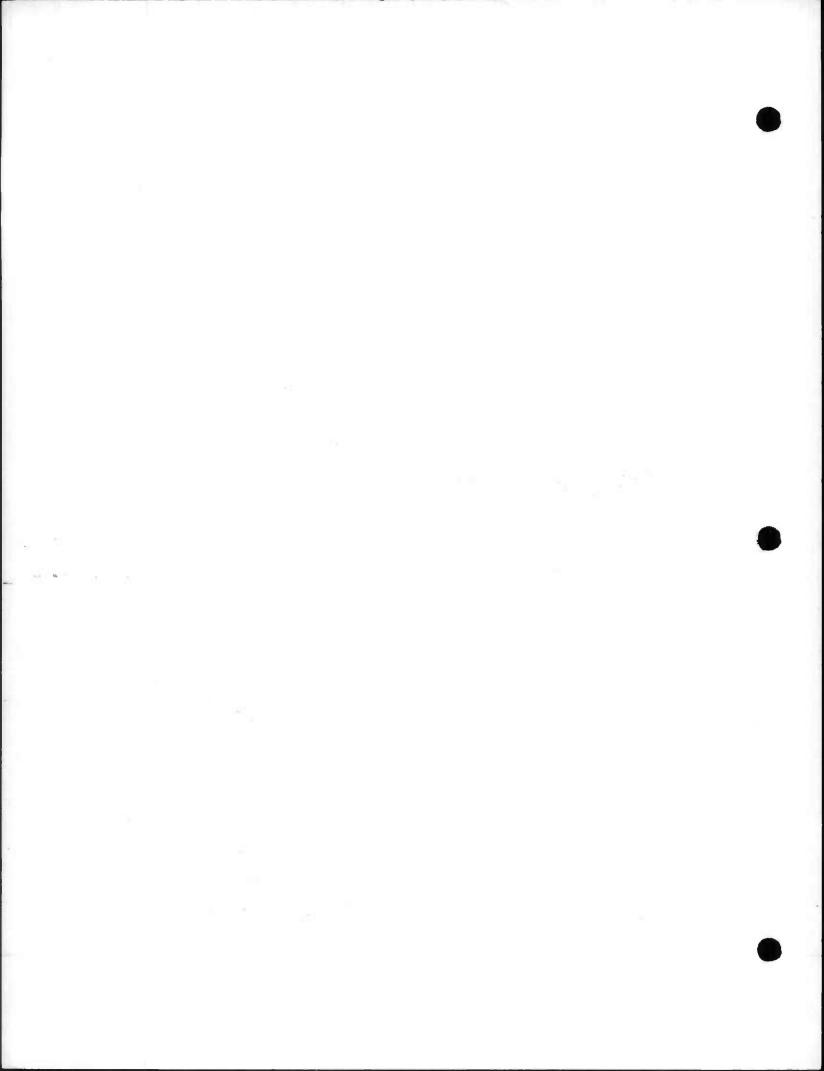
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

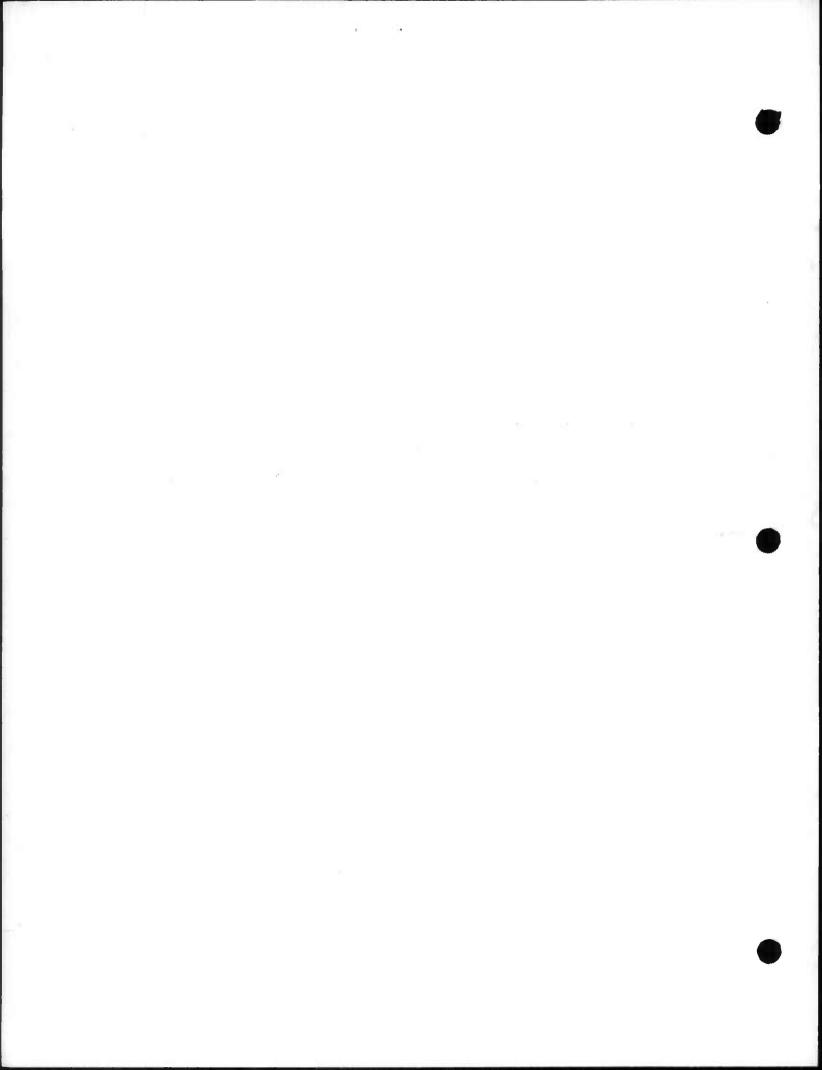
6

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO		
- 8	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF DEATH
- 8	LEMUEL PEARI		H	EDRICK		FEB 23	1995	2:50 P.M. M
	4. SOCIAL SECURITY NUMBER 5. SI	7	in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.18	IRTHPLACE (State or Foreign
	705-10-7322	IM 2 □ F 96	YRS.	MONTHS DAYS	HOURS MIN.	FEB 11. 9 Year 18	399	W.VA.
	9a. FACILITY NAME (If not institution, give street ar	nd number)		9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUNTY	OF DEATH
OH	MEMORIAL HOSPITAL			CUMBER	RLAND		ALLEG	ANY
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY							
E	MARYLAND ALLEGAN	177		y, town or locat MBERLANI				10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	NI.	- 00					XX YES 2 NO
FUNERAL	215 CECELIA STREET			101	2150)2	10g. CITIZEN U . S	of what country?
S	11. MARITAL STATUS 12. V	MAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No.— 14.	RACE — American Indian.
8≺		FORCES? 1 TYES FYES, GIVE WAR OR DA		It yes, sp	2 NO Specify	n, Puerto Rican, etc.)		Black, Whita, atc. Specify: WHITE
	15. DECEDENT'S EDUCATION (Specify only highest grade comple		18a. DECEDENT'S	USUAL OCCUPATIO	ON et of working	16b. KIND OF BUS	SINESS/INDUST	RY
9	Elementery/Secondary (0-12) Coli	lege (1-4 or 5+)		vork done during mo e retired.)				
COMPLETED	5		WESTERN	MARYLANI	RAILROA			
8	17. FATHER'S NAME (First, Middle, Last) JOSEPH PERRY HEDRIC	CV				ME (First, Middle, Maiden CH REXRODE	Surname)	
8	19a. INFORMANT'S NAME (Type/Print)	CK	40					
۵	WALTER R. HEDRICK					R, SOUTH CA		
	20e. METHOD OF DISPOSITION 1 X Surial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify)		PLACEAND DATE OF		me of RY FEB 26	DATE 20c. LO	CATION — CHY O	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1 -1	_	22. NAME AL	D ADDRESS OF FA	FUNERAL HO)ME	
	Dale L.	erull		404 DI	ECATUR ST	TREET CUMBI	ERLAND	MARYLAND
	23. PART i. Enter the diseases, or complishock, or heart failure. List o	cetions that ceused	the death. Do n	ot enter the mo	de of dying, suci	h as cardiec or reepi	retory arrest,	Approximate
	IMMEDIATE CAUSE (Fine)	my one couse on ee	our mine.	•				Interval Between Onset and Death
	disease or condition resulting in death)	1/	Viose 1	2575				3 done
		DUE TO (OR AS A	CONSEQUENCE/O	2. /)	/:		1
Z	Sequentially list conditions, b.	0	sorile		enan of	sa		6yours
Ĕ	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	7):				
E C	CAUSE (Disease or injury C. —	DUF TO (OR AS A	CONSEQUENCE OF	n.				
CERTIFICATION	thet initiated events resulting in death) LAST	- TO (O.1. A.5 A	CONSCOULAGE OF					j
E	d							
	PART ii. Other significent conditione con	tributing to death bu	it not reculting i	n the underlying	ceuee given in	Pert i. 24s. WAS AN PERFOR	AUTOPSY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL						1 YES 2	1	COMPLETION OF CAUSE OF DEATH?
ME								1 YES 2 NO
	DID TOBACCO USE CONTRIBU	TE TO CAUSE OI	F DEATH YE	S INO I	UNCERTAIN			
당	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPAL:	6. PLACE OF DEAT					
XS.	1 U YES 2 D 1		itlent 3 🗆 DOA	OTHER: 4 Nursing Hom	5 Rasidence	8 Other (Specify)		
PHYSICIAN:	Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI INJ	URY WO	URY AT RK? 'ES 2 NO	28d. DESCRIBE HOW II	JURY OCCURE	D
D 8Y	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, term, a			281. LOCATION (Street a	nd Number or Ru	iral Route Number,
COMPLETE	4 Homicide determined	building, atc. (Speci	(4)			City or Town, State)		
릴	29a. CERTIFIER CERTIFYING PHYSICIAN: 1							
Š I	one) 2 MEDICAL EXAMINER On 1	the beels of examination	and/or/investigatio	n, in my opinion, d	eath occured at the	time, data and place, en	d due to the cau	se(a) and menner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		3		29c. LICENSE NUM	BER 17/ /	29d. DATE SIG	AED (Month, Pay, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COM	DI STED OUT	711 #200		V 36	166	12/	1415
	DR. VIK POONAI	719 Willia	TH (ITEM 27) (Type, MS STREE	T Cumb	erland	766 Maryland	21502	
	31. DATE FILED (Month, Day, Year) FEB 2 7 1995	32 REGISTRAR'S SIGNA	TURE Randall					
	FEB 2 7 1995	procession of the second						



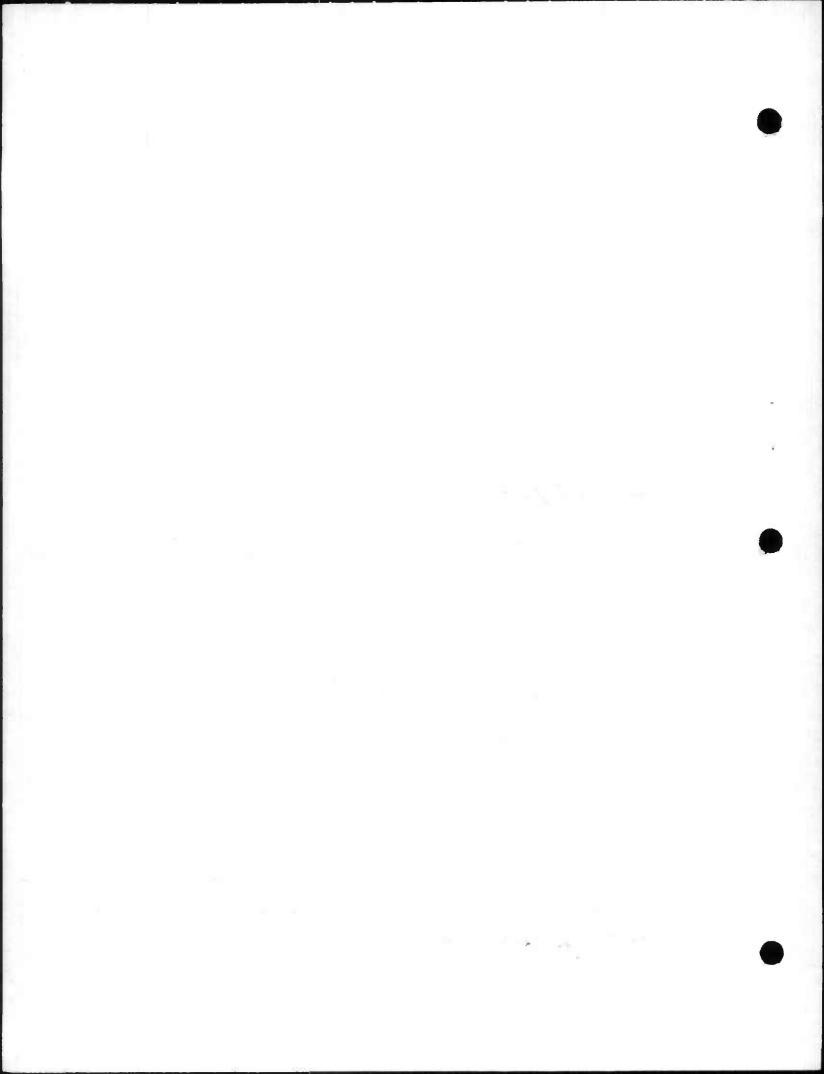
DHMH-18 Rav 1/89

)		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DE	PARTME TIFICA	NT OF H	EALTH AND	MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	DAY	MEAG	3. TIME OF DEATH
		Elizabeth Mor						March 5		1995	5:45 AM
		4. SOCIAL SECURITY NUMBER	7.1	(In yrs. lest birti	MONTE	DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	PLACE (State or Foreign
pin		215-42-0778 9a. FACILITY NAME (If not institution, give	1 M 2 🔀 7	8 Y	RS.			Nov. 15,			
3 should	Œ	Harford Memorial					e Grace	EATH		rford	
1. 2.	CTOR	RESIDENCE OF DECEDENT	110072002		1110	TVIE O	e Grace		na	riora	
Pages	Ш	10a. STATE 10b. COUNT	TY	10-	c. CITY, TOW	N OR LOCAT	ON				10d. INSIDE CITY
permit. P	DIR.	Maryland	Harford		Aberd	een					TYES 2 NO
ued #	ERAL	10e. STREET AND NUMBER				10f.	ZIP CODE		10g. CI	TIZEN OF W	HAT COUNTRY?
発音	N	5 Oakdale Street	12. WAS DECEDENT EVER II	NIII ADVICE			21001			S.A.	
020 physician burlaf-trar	FUNI	1 Never Married 2 Married	FORCES? 1 YES	270NO		If yes, spe	cify Cuban, Maxica	NIC ORIGIN? (Specify Y in, Puarto Rican, etc.)	ea or No—		— American Indian, t, Whita, etc.
9 2 2	ВУ	3 Widowed 4 Divorced	IF TES, GIVE WAR OR D	MIES		1 U YES	2 NO Specif	y:		Whi	
21215 at or attend for une as	田	15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	(Give kii	ENT'S USUAL	ne dudina mai	N I of working	16b. KIND OF B	USINESS/IN		
	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfe. Do I	VOT usa retire-	d.)					
No section of the sec	N N	17. FATHER'S NAME (First, Middle, Last)	0	Home	maker			In ho			
at the state of th	EC	John H. Morrison						ME (First, Middle, Maide h Carter	n Surname)		
MAR retained 5 should notified	0	19a. INFORMANT'S NAME (Type/Print)		19b. MA	ILING ADDR	ESS (Street ar		Aoute Number, City or To	wn Stele 7	in Code)	-
	임	Mr. Richard L. H	arrison					Aberdeen			21001
W DA A		20a, METHOD OF DISPOSITION 1	200	. PLACE AND	ATE OF DISP	OSITION (Na/	ne of		OCATION -		
MOR age 6 mu finector, 1		4 Donation 8 Dother (Specify)	Ha	arford	Memo	rial (Gardens	3/9 Ab	erdee	en, Ma	aryland
ALTIR death. Pa t honeral of t examiner		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		. 1	Tarr	ADDRESS OF FA	o Funeral	Home	. P 7	4
		Baryk	Didiov	anni				ryland 2			•
n ty nemo		23. PART I. Enter the diseases, or shock, or heart failure.	complications that cause List only one cause on a	d the death.	Do not en	er the mod	le of dying, auc	h aa cerdiec or ree	piratory ar	rreat,	Approximata
2 - 2		IMMEDIATE CAUSE (Final				1.	.00	11 17			Onset and Dead
- PE -		disease or condition resulting in death)	. Utill	aut	SIN	\mathcal{U}	all	MI			Zady
S 2 2 2 5	_	_	DUE TO (OR AS A	A CONSEQUEN	CE OF):						
OX 687 e be executed sician and con rior to burial, traumatic er	CATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR AS A	CONSEQUEN	CE OF):						
prior tra	S	ceuse. Enter UNDERLYING CAUSE (Disease or Injury	c								!
other ph of the C	RTIF	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUEN	CE OF):						
death certificate attending physicarial Hygiene print, or other to	H	Todating in castily exist	d								
宣言音音音	AL	PART II. Other eignificant condition	ne cantributing to deeth b	out not resul	ting in the	underlying	ceuse given in		N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
S a a a a	DIC	Diag	sell,					1 _ YES	2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
requires that shows and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show a show and shows a show a s	MEDIC							_ /	(~		1 TES 2 THO
AL ME e law requ has been Dept. of I	ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE O				UNCERTAIN	1 X			
F 2 2 5	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF	OTH	ER:	/				
SICIAN: The Certificate the State	HYS	1 YES 2 NO	1 Inpetient 2 ER/Outp		OA 4 🗆 N	28c, INJU		8 Other (Specify)	TO 11 11 10 11 10 10 10 10 10 10 10 10 10	au in the	
NG PHYS fler this marked		1 Netural 5 Pending	(Month, Day, Year)	200	INJURY	WOF	ES 2 NO	28d. DESCRIBE HOW	INJURY OC	CURED	
WDING WDING IS After death	Э ВҮ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	— At home, to	erm, street, t			281. LOCATION (Street		r or Rural A	oute Number,
2 # 5 # 52 2 # 5 # 52	Ē	4 Homicide detarmined	building, etc. (Spec	ciry)				City or Town, State	9)		
E 6 6 6	COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	ledge, dasth o	courred at th	time, data a	ind place, and due	to the cause(a) and ma	nner as sta	nted,	
HOSPITAL FUNERAL Within 72 TANT: If	OM		ER: On the beals of examination								and manner as stated.
TO THE HOSPITAL. TO THE FUNERAL De filed within 72 IMPORTANT: If	BE C	296. SIGNATURE AND TUTLE OF CERTIFIE	R ,	= 1		0.4	20c. LICENSE NUN	MBER	29d.,DAT	TE SIGNED	(Month, Day, Year)
E E S W	TO B	Vivele -	11-0/ 10) C	Mec	(Rus	A 05	8334	M	with	5.1981
	F	30. NAME AND ADDRESS OF PERSON WH		ATH (ITEM 27)	(Type, Print)	0	000	0. 1-	^	,	
		,,,,			Veel	22m	1 Bel	au M	1721	011	
		MAR U 6 1995	Julia Davelson								
		MAIL V 0 1333	your amount	Mardal							



1 - FOR STATE REGISTRAR

		REGISTRAR		CERTIF	ICATE (DE DEATH	REG. NO	1.	
		1. DECEDENT'S NAME (First, Middle, Last)	He Mai	tia	Jou	nes	2. DATE OF DEATH DON'TH DE	ZZ1995	3. TIME OF DEATH A
P		4. SOCIAL SECURITY NUMBER 188-09-5467	1 M 2 LE	(In yrs. last birthday)	MONTHS DA		7. DATE OF BIRTH / (Month, Day, Year) Oct. 6 19	8. BIF	ATHPLACE (State or Foreign unity)
should	_	9e. FACILITY NAME (If not institution, give st	reet end number)		9b. CITY, TO	N OR LOCATION OF D	EATH	9c. COUNTY OF	
.2.3	DIRECTOR	Washington County RESIDENCE OF DECEDENT	Hospital		На	gerstown		Washi	ngton
Pages	2	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR L	OCATION			10d. INSIDE CITY LIMITS?
permit. P			shington		Hagers	town			1X YES 2 NO
it pen	ERAL	100. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
rian.	N N	1322 Potomac Avenu		11110 101100		21740		U.S	
or attending physician.	BY FUN	1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 (X)NO	If yes	DECENDENT OF HISPAI I, specify Cuben, Mexics YES 2 NO Specif		Bi	ACE — American Indian, ack, White, etc. ec/ly: White
attend as se as	E C	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16e. DECEDENT'S	USUAL OCCU	PATION	16b. KIND OF BUS	SINESS/INDUSTRY	
ital or atte	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	7 most of working			
the hospital detached to	ME	12 17. FATHER'S NAME (First, Middle, Last)	I	File	Clerk		REtail		
by the		Clarence Martin					ME (First, Middle, Maiden	Surname)	
retained by the 5 should be contified at contified at continuous c	BE	190. INFORMANT'S NAME (Type/Print)		19b. MAIL INC	ADDRESS (Str		Jameson Route Number, City or Tow	on Chair Tin Code!	
	5	David Forbes Jone	2.5				lagerstown,		nd 217/0
6 may be ctor, page		20g, METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITIO	I /Name of	OATE 20c LO	CATION — City or	
0 0	1 1	1 🗓 Burlel 2 🗆 Cremation 3 🗔 Remo	R R	est Have	n Ceme	tery 2-25-	_ L		Maryland
death. Page 6 m tuneral director, i. examiner must	1	21. SIGNATURE OF FUNERAL SERVICE LICE		` /			CLUTY Minnich		
		Day	Mumu	16					, Md. 21740
ed within 24 hours ompletely filled in il, cremation, or ri event, the med		23. PART I. Enter the diseasea, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Adenolo	each line.	na c		Byeos		Approximate intervel Between Onset and Desth
th certificate be execu- ending physician and il Hyglene prior to bur or other traumalle	CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		A CONSEQUENCE O					
the death the atter Mental		PART II. Other algnificent conditions	contributing to death,	out not resulting	in the under	ying cause given in	Part I. 24s. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS
SICIAN: The law requires that the dea certificate has been signed by the art the State Dept, or Health and Mental, or Item 23 shows any Injury,	N: MEDICAL	COVERNO VOSC DID TOBACCO USE CONTR	view Ac	Merris.	sclen	,	PERFOR 1 □ YES 2	IMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
N: The ficate ha State D	5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEA		ine)			
ICIAN: entification the St	PHYSICIAN:	1 TES 2 NO	1 Datient 2 ER/Out	patient 3 DOA	OTHER:	lome 5 - Residence	8 Other (Specify)		
The this	ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM	URY	INJURY AT WORK? YES 2 NO	26d. DESCRIBE HOW IF	YJURY OCCURED	
OR ATTENDING DIRECTOR; After hours after death tem 28 Is ma	8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	f — At home, farm, scify)	street, fectory, o	ffice	28f. LOCATION (Street e City or Town, State)	nd Number or Rura	l Route Number,
	P.E.	29e. CERTIFIER (Check only	IAN: To the best of my know	rledge, death occum	ed at the time,	late end place, and due	to the cause(e) and men	ner ee stated.	
HOSPITAL FUNERAL within 72	COMPLET		: On the besie of examination						e(e) and menner ee stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If		296. SIGNATURE AND TITLE CERTIFICATI	now R	9 11	11	29c. LICENSE NUN			ED (Month, Day, Year)
TO THE De filed	TO BE	30. NAME NO ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OR	ATH (ITEM 27) (Type	Maa	i Do	4359	► [el	22,1995
		31. DATE FILED (Month, Day, Year)	L 32. REGISTRAR'S SIGN	1459	Po	tomac +	tue	Hoger	etown
		FEB 2 4 1995	alluction Revela	4				L	



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						02111111	IOAII	_ 01	DEA	111	P	IEG. NU.			
		Josephine C		TACKSO	M						2. DATE OF MONTH Februa	DA	, 20 1	YEAR	1:38 p. M
		4. SOCIAL SECURITY NUME		5. SEX	rs. last birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH	10, 1	8. BIRTHP	LACE (State or Foreign	
pj.		220-30-956		1 🗌 M 2 💢 F	8	81 YRS.	MONTHS	B DAYS HOURS MIN. May 13, 19					913 Maryland		
3 should	Œ	90. FACILITY NAME (If not in Ravenwood			ana		1	r, тоw и с jerst	ON LOCATIO	ON OF DE	EATH			NTY OF DE	
1, 2,	СТОВ	RESIDENCE OF DEC		an villo		Hay	JC 1 3 (JOWIT				WdS	hingt	OH	
Sages	DIREC	100. STATE Mary Tand	10b. COUNTY	, nington			Y, TOWN		TION						IOd. INSIDE CITY
Ĭ.		100. STREET AND NUMBER	Wasi	rrigton		3110	rpsb		I. ZIP CODE				40- 017		YES 2 NO
physician. burial-transit permit. Pages	FUNERAL	107 E. Ant				217				log. Citi	USA	AT COUNTRY?			
rsician rial-tra	2	11. MARITAL STATUS	S. ARMED	13.	WAS DEC	ENDENT O	F HISPAN	NIC ORIGIN? (S	pecify Yes	or No —	14. RACE -	- American Indian, White, atc.			
Nours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran or removal. medical examiner must be notified at once.	B	1 Never Married 2 3 Widowed 4 Divo	sX			2 NO	Specif		n, wc.,			White			
use as	밀	15. DEC (Specify only	Give kind of	work done	during mo		g	16b. KIN	ID OF BUS	INESS/INC	DUSTRY				
pital o	PE	Elementary/Secondary (0	Housew						Home						
the hospital o detached for once.	COMPLET	17. FATHER'S NAME (First, M	iddle, Last)						1a. MOTH	IER'S NA	ME (First, Midd	_	Surname)		
d by the	BE	George Was		n Church	ey						Franc				Lewis
retained 5 should notified	2	19a. INFORMANT'S NAME (1									Aoute Number, (00000
ay be	Ŋ	Harry W. H	ION		20h PI	ACE AND DATE				. P	almyra			City or Town	08065
e 6 may rector, p must		1 Buriel 2 Cremelic 4 Donation 5 Other		oval from State	cemeter Mt.	View Ce	ther plece,	y Fe	b. 23,	199	5	l .			21782
death. Pag tuneral di examiner		21. SIGNATURE OF EUNERAL SERVICE ADDRESSEE / 22								S OF FA	CILITY			27,	
the fur val.		1////	-14/1	- am			P.0	O.BOX	348	Wi.	11 iamspo	ort, M	d. 217	795	
y fill		23. PART I. Enter the deposit, pr h IMMEDIATE CAUSE (Fir disease or condition resulting in deeth)	eert fellure.	e	AS (ONSEQUENCE O		r the mo	oda ot dyi	ng, auc	h as cerdiac	or respi	ratory arr	reat,	Approximata interval Between Onset and Death
executed n and con to burial,	NOI	Sequentially list condit		b. DUE TO	HOR ASMAGE	MSEQUENCE O	F):								
ysiclar prior	ICAT	if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju	NG	c	-111										
n certificat inding phy Hygiene p or other	ERTIFICATION	that initiated events reaulting in deeth) LAS		DUE TO	(OR AS A CO	INSEQUENCE O	IF):								
the death y the atter of Mental Injury, o	0	DARY II Osban significa		d											1
uires that signed b Health ar	4: MEDICAL	PART ii. Other signitics	Mme	1 and		TUS		My	11/	y)		I. WAS AN PERFOR	MED?	1 8	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
Item 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MESTCAL	HOSPITAL:					LACE OF DE	EATH (Ch	eck only one)				
PHYSICIAN: The law req this certificate has been with the State Dept. of rked, or Item 23 sho	IXSI	1 YES 2 SMO		1 Inputlant 2				rsing Hom		sidence	8 Other (Sp				
DING PHYSI After this c death with s marked,	ву рну	1 Natural 5	Pending Investigation	28a. DATE Of (Month, L		28b. TIA	JURY M	WO	IURY AT DRK? YES 2	NO NO	28d. DEŞCRII	BE HOW II	IJURY OC	CURED	
OR ATTENDING DIRECTOR: After hours after death	ETED (Could not be determined	28e. PLACE (building.	OF INJURY — , etc. (Specify)	At home, ferm,	street, lac	tory, offic	•		281. LOCATIO City or To	IN (Street a wn, State)	nd Number	or Rural Ro	ute Number,
HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours TTANT: If Item	COMPL			CIAN: To the best of											and manner as stated.
TO THE HOSPIT TO THE FUNER DE filed within T	O BE	29b. SIGNATURE AND TITLE	murf	Charl	un	0			29c-LICE	661	WHER		29d. DAT	E SIGNED (A	Month, Day, Year)
		30. NAME AND ADDRESS OF	117	AETNA	SE OF DEATH	(ITEM 27) (Type		120	un						
, l		FEB 2 3 199	5" Jul	S RECUSTR	ARY SIGNATI	RE	/								

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an interpretate of the following physician and completely filled in by the funeral direction page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

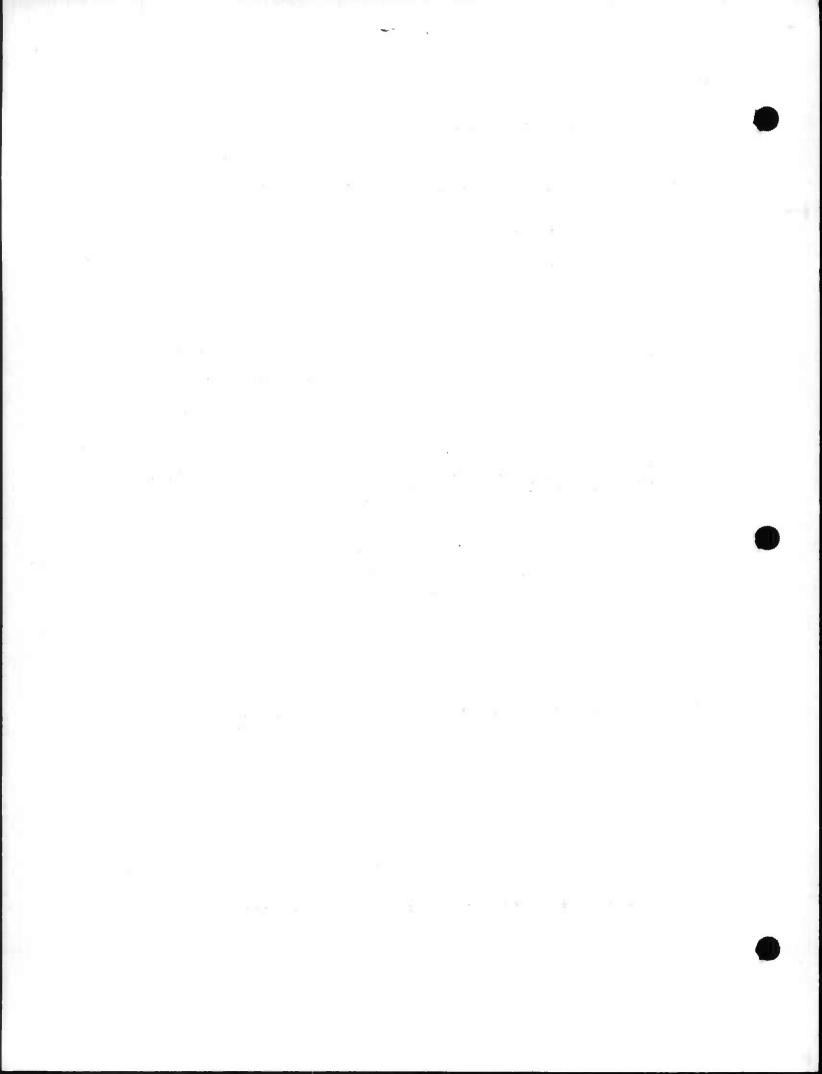
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	Mabel B	eatrice	2 JOHNS	ON						February	20.	1995	12:30B
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER		IF UNDER	-	7. DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	216-22-2.	587	1 🗌 M 2 🔯 F	75	YRS.	MONTHS	DAYS	HOURS	MIH.	Oct. 12,1	919	Ma	ryland
	90. FACILITY NAME (If not is					9b. CITY,	TOWN	OR LOCATI	ON OF DE			NTY OF D	-
DIRECTOR			ING CENT	ER			So1	omon	S		Ca	alve:	rt
2	RESIDENCE OF DE	10b. COUNTY			10c CIT	r, TOWN O	BIOCA	TION					10d, INSIDE CITY
HO I	Maryland	Calv	ert					ake :	React	า			LIMITS?
7	10e. STREET AND NUMBER					-	<u> </u>	f. ZIP COD		-	10a, CITI	ZEN OF V	1 ☐ YES 2 ☑ NO
EB/	6626 Old	Bayside	Road					207	32		US		The souther
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13. 1	MAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify Yea	or No-	14. RACE	. — American Indian,
BY F	1 Never Married 2 3 Widowed 4 Dive		FORCES?	YES 2 XN		31	f ves. so	ecify Cuba	n. Mexicar	n, Puarto Rican, etc.)		Speci	, White, atc.
- 1						1							Black
COMPLETED	(Specify on	y highest grade	CATION completed)	(G/	VE kind of v Do NOT us	vork done o	CCUPATIO	ON ost of working	ng	18b. KIND OF BUS	INESS/INC	USTRY	
PE	Elementery/Secondary (I	0-12)	College (1-4 or 5	+)	ousew					Own 1	Home		
WO	17. FATHER'S NAME (First, N	liddle, Last)						16 MOTI	HED'S MAA	ME (First, Middle, Maiden			
	Russell		Jo	nes					ctrud		Surname)	Tv	ler
BE (19a. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS	(Street a			loute Number, City or Town	n, State, Zip		101
2	Betty	Brow						ane		ple Hills			8
	26e METHOD OF DISPOSIT 1 Buriel 2 Crematic 4 Donation 5 Other	TION on 3 ☐ Remo (Specify)	wal from State	20b. PLACE A	matory or of	her place)	TION (Na	Cami	1	DATE 20c. LOC	CATION —	City or To	wn, State
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	- Joodene	ELII I	22.1	TAT	ND ADDRES	SS OF FAC	Sewell	Func	K, M	U
	Sher	cer	8 Ser	valo		14	51 I	Dares	Bea	ch Rd. Pri	ince	Fred	erick, MD
	23. PART I Enter the d shock, or h	iseesea, or c eert feliure. L	omplications the	t ceused the de-	eth. Do n	ot enter	the mo	de of dy	ing, such	as cerdiec or respi	ratory err	est,	Approximate interval Batween
1	IMMEDIATE CAUSE (Findisease or condition		1.7			1							Onset and Deeth
	resulting in death)	→ ,	. I'le	Tolstat	70	L	w	v9 (are	inom			
_) A	(OR AS A CONSEC	L/): ∵€				inom			
CERTIFICATION	Sequentially list condit			(OR AS A CONSEC		ron							
CA	cause. Enter UNDERLY CAUSE (Disease or inju	ING											
	that initieted eventa reaulting in death) LAS		DUE TO	(OR AS A CONSEO	UENCE OF):							
H	resulting in death) LAS		i										
	PART ii. Other significe	nt conditions	contributing to	deeth but not re	esulting i	n the un	deriying	g ceuse g	given in I	Part I. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
											TA SALO		DF DEATH?
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Z I	25. WAS CASE REFERRED T EXAMINER?				E OF DEAT								
is I	1 YES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER Nurs		e 5 □ Re	aldence (3 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF (Month, D		28b. TIME INJ		28c. INJ WO	URY AT		28d. DESCRIBE HOW IN	LJURY OCC	CURED	
B		Pending Investigation				М		rES 2	NO				
- 111		Could not be datermined	28a. PLACE O building,	F INJURY — At hor atc. (Specify)	ne, ferm, a	treet, facto	ry, office	•		2sf. LOCATION (Street a City or Town, Stete)	nd Number	or Rural R	oute Number,
	29a. CERTIFIER								<u> </u>				
COMPLETED	(Check only									to the cause(e) end man			and manner as stated.
	296. SIGNATURE AND TITLE		1	05				29c LICE	NSF NUM	BER	29d DATE	SIGNED	(Month Cay Mar)
의 일 일	La constitución en calcidado de la constitución de	0	Mar	m)				D	375	588	> 2	2 - 2	2-95
-	30. NAME AND ADDRESS OF RAPIK	A 1	ASP.	SE OF DEATH (ITEM	127) (Type,	Print)	20	us	Seau	e RJ#10	9 /	suce f	2-95 Reduck Md
	31. DATE FILED (Month, Day.			R'S SIGNATURE	1								
	FEB 24	1995	Jalia Dau	iden Rarda	Ц.								

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OSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fact death. Page 6 may be retained by the hospital or attending physician.	e attending physician and co	State Dept. of Health and Me	NT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comple	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cre-	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic even

	1 - STATE REGISTRAR	STATE OF MARYL		ATE OF D		MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)		<u>GEITTI TO</u>	AIL OI L	LAIII	2. DATE OF DEATH			3. TIME OF DEATH	
	MATTHEW J JO	OHNSON, SR.				MONTH D		YEAR	9:04	DM
	4. SOCIAL SECURITY NUMBER				IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Fore	
	214-12-7816 A 90. FACILITY NAME (If not institution, give si	1 M 2 F 84	YRS.	b. CITY, TOWN OR	OCATION OF DE	AUG. 1,19	10		GINIA	
DIRECTOR	FORT WASHINGTON M			FORT WAS					EORGE	
EC	10e. STATE 10b. COUNTY	,	10c. CITY, 1	TOWN OR LOCATION	N				10d. INSIDE CITY	
	MARYLAND PRINCE	GEORGE	OXON	HILL					LIMITS?	0
FUNERAL	10e. STREET AND NUMBER			101. ZI	IP CODE		10g. CITIZ	EN OF W	HAT COUNTRY?	
Ä	#7212 CLOVERDALE			20)745		UNIT	ED S	TATES	
E	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES				IIC ORIGIN? (Specify Yearn, Puarto Rican, etc.)	or No-	14. RACE Black	- American Indian, White, etc.	
BY	3XXWidowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 TYES 2	NO Specify	/:		Specif	BLACK	
	15. DECEDENT'S EDUC	CATION	16e. DECEOENT'S US			16b. KIND OF BU	SINESS/IND	USTRY	DLACK	
COMPLETED	(Specify only highest grade Elementery/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life, Do NOT use n	k done during most o etired.)	of working	100000000000000000000000000000000000000				
AP.	3RD. GRADE		LABORER			PRIVA	ΓE			
Ö	17. FATHER'S NAME (First, Middle, Last)			1		ME (First, Middle, Maiden				
BE	MATTHEW JOHNSON			E	EULA RUI	TH BERSHRO	D			
6	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow				
	HILDA FORD					E, OXON HI				5
	20a. METHOD OF DISPOSITION 1 N Burlet 2 Cremation 3 Remo		PLACE AND DATE OF I letery, crematory or other ILOH CHUR			1	CATION —			
	4 Oonation 5 Other (Specify)	ENSEE 1	TLOH CHUR		ADDRESS OF FA		BURG,	MAR	YLAND	
	Mudda C. W	Theretoh At	HAND TOO	THORNTO	ON FUNER	RAL HOME,				
		TON JOHNSON				ON ROAD, I			D, MD.20	640
	23. PART I. Enter the disesses, or of ahock, or hasrt fallura.	complications that caused List only one cause on e		enter tha mode	of dying, auci	h as cardisc or reap	iretory arre	est,	Approximate Interval Bat	
	IMMEDIATE CAUSE (Final disesse or condition	0 0:	0		+				Onsat and I	Death
- 4	resulting in death)	Carellow	CONSEQUENCE OF	zy ars	rest				-	
		cancer	· 1 0	1/2						
<u>ō</u>	Sequentially list conditions,		CONSEQUENCE OF):	71.						
		OUE TO (OR AS A		1 1 11 4						
CAT	cause. Enter UNDERLYING	cancer .		Hale						
FIFICAT	cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events	cancer .	CONSEQUENCE OF	Hall						
ERTIFICAT	cause. Enter UNDERLYING CAUSE (Disesse or injury	cancer .		Hali						
L CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST	c. Cancer Due to COR AS A	CONSEQUENCE OF)	Whate	suse given in	Part i. 24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINC	HNGS
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COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A CO D. Secontributing to death b CONTRIBUTE TO HOSPITAL: 1 Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec	ut not resulting in CAUSE OF Setient 3 DOA 4 28b. TIME C INJUR At home, ferm, stre	DEATH YE 28. PLAC DTHER: Nursing Home 28c. INJUR WORK 1 YES eet, fectory, office at the time, date en in my opinion, deat	S NC E OF DEATH (Chr. 5 Residence 7 AT 2 NO ad place, and due th occurred at the 9c. LICENSE NUM D 0 9 1 (PERFOR 1 YES 2 Bock only one) 6 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(e) end maintained time, data and place, end ABER	NJURY OCC	UREO or Rural R od. o cause(e)	AMALABLE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO COMPLETION OF CALOUTE PRIOR TO CALOUTE PRIOR T	PSE

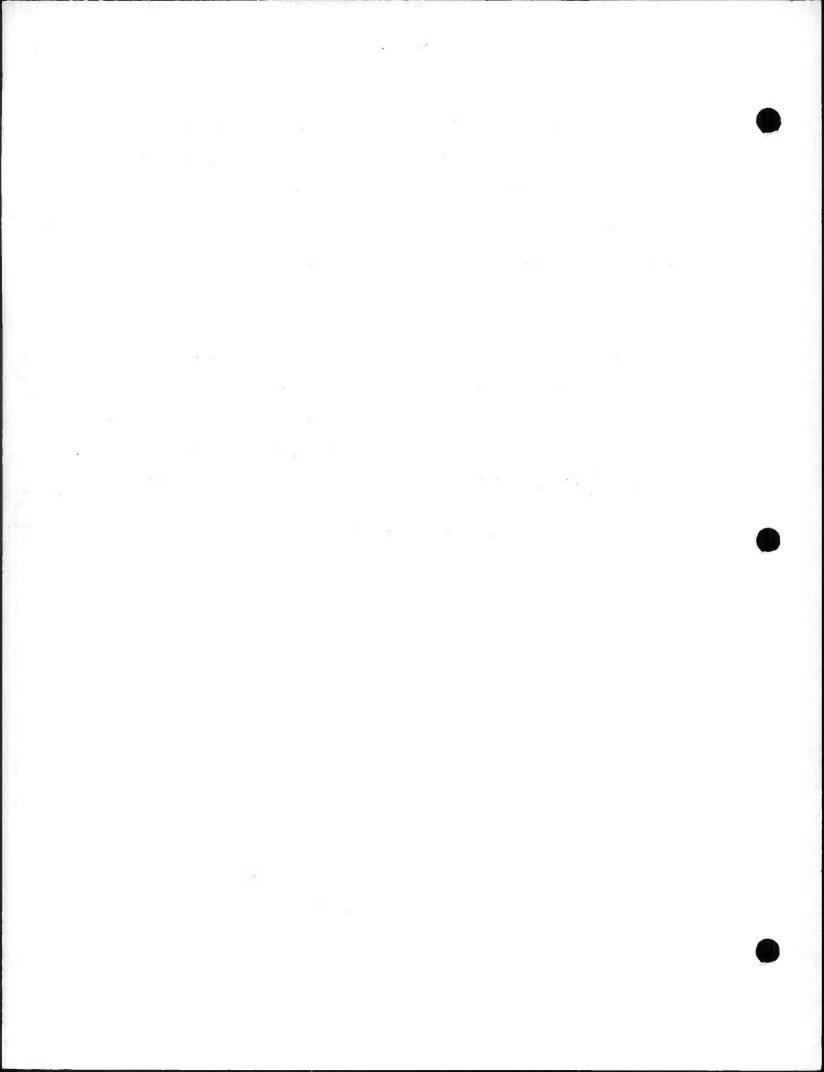


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

0000	ng physician.	he burlal-transit permit. Pages 1, 2, 3 should	
מאוים וועשורי שועשורים	death. Page 6 may be retained by the hospital or attend	funeral director, page 5 should be detached for use as	examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Debt of Health and Mental Hymlene prior to burial cremation, or removal	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIA	TO THE FUNERAL DIRECTOR: After this certile field within 72 hours after death with the	IMPORTANT: If Item 28 is marked, or

	1 - FOR STATE REGISTRAR	STATE OF MARYL				EALTH AND DEATH	MENTAL	HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE C	F DEATH			3. TIME OF D	EATH
	Jack	MATTHE	w J	ohns	on J	JR.	Febr	uary		995	11:1	9 а.м
į	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birt	hday) IF UNI	DER 1 YEAR	IF UNDER 24 HRS.	7. DATE O		7	S. BIRTH	PLACE (State o	
	219-34-8764 90. FACILITY NAME (If not institution, give s	t M 2 F 5	7	RS. MONTH		HOURS MIN.	SEPT		1937	MA NTY OF D	RYLANI)
DIRECTOR	Physicians Me		pital		LaP						rles	
) EC	10e. STATE 10b. COUNTY	Y	10	c. CITY, TOWI	N OR LOCAT	ION					10d. INSIDE	CITY
	MARYLAND CHAR	RLES		THOMPS	SKINV	LLE				l	LIMITS?	₩ NO
AL	10e. STREET AND NUMBER				101	ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTR	Y?
Ē	#14625 SOUTH CUCH	KLAND ROAD				20664			UNIT	ED S	TATES	
FUNERAL	11. MARITAL STATUS 1 Never Merried 2 XX Merried	12. WAS DECEDENT EVER I		1		ENDENT OF HISPAI			or No-	14. RACE Black	- American White, etc.	Indien,
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES			2XXNO Specif				Spech		,
	15. DECEDENT'S EDU	1961-1963 CATION	18e. DECEDI	ENT'S USUAL	OCCUPATIO	M	146.1	(IND OF BUS	INTERE /IND	LICTRY	DDAOI	`
ETE	(Specify only highest grade Elementery/Secondary (0-12)	College (t-4 or 5+)	10hm bi	ind of work dor NOT use retired	no divina ma	a miles mental man	155.	CIND OF BOX	MINESS/IND	OSTAT		
7	12TH GRADE					CHANIC	U	.S. G	OVERN	MENT	•	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Mi	ddle, Malden	Sumeme)			
BE (MATTHEW JACK JOHN	ISON, SR.				OPHELIA	MEVE	LLE W	ASHIN	GTON	JOHNS	ON
TO E	19e. INFORMANT'S NAME (Type/Print)					nd Number or Rural						
-	MARY MARGARET JOH		#14	625 SC	OUTH (CUCKLAND	ROAD	, NEW	BURG,	MD.	20664	+
	20a, METHOD OF DISPOSITION 1 N Burlal 2 Cremetion 3 Rem	oval from State 20t	netery_cremato				DATE		CATION —	•		
	4 Donetion 5 Other (Specify) 21. SIGNADURE OF FUNERAL SERVICE LIC	TENOGE O	ARYLAN			EM. 3/6				IAM,	MARYLA	AND
	BURIA Co Thon	the HARS	n/		THORN	ON FUNE	RAL H	OME, I	P.A.			
		NTON JOHNSON				IVINGST					D, MD.	2064
i	23. PART I. Enter the diseases, or c shock, or heart fallure.	complications that cause List only one cause on a	d the deeth.	Do not ent	ler the mo	te of dying, suc	h as cardle	ec or respi	ratory arr	est,	Approx	imate I Between
	IMMEDIATE CAUSE (Finel disease or condition	m 11	1-1	M	Deme .							and Death
	resulting in death)	e. DUE TO (OR AS	1/	1 mg	Colum							
_	_	PO A	C.	CEJOFIJ								
ģ ∣	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUEN	ICE OF):							-	
S	cause. Enter UNDERLYING	a and	MUN									
Ė	CAUSE (Disease or injury thet initiated events	DUE TO TOP AS	CONSEQUEN	ICE OF):								
CERTIFICATION	resulting in death) LAST	d										
AL C	PART II. Other significent condition	s contributing to death it	out not resul	Iting in the	underlying	csuee given in	Part i.	4a. WAS AN	AUTOPSY	24b.	WERE AUTOPS	Y FINDINGS
								PERFOR			AVAILABLE PRI	IOR TO
입								YES 2	∐ NO		OF DEATH?	□ мо
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH	YES 🗆	NO 🗆	UNCERTAIL	ΝП				1 TES 2	NO
Ν	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF	DEATH (Chec	ck only one)							
SIC	t YES 2 NO	HOSPITAL: 1 Inputient 2 ER/Out	patient 3 🗆 D	OTHI		5 Residence	S - Other (Specify)				
E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	284	b. TIME OF	28c. INJU		28d. DESC	RIBE HOW II	JURY OCC	URED		
ВУ	t Natural 5 Pending 2 Accident Investigation			М	1 🗆 Y	ES 2 NO						
	3 Suicide S Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, f	ferm, atreet, fe	ectory, office			ION (Street a Town, Stete)	nd Number	or Rural R	oute Number,	
릴		CIAN: To the best of my know										
COMPLET	2 MEDICAL EXAMINE	R: On the beels of exeminatio	n end/or inves	tigation, in my	y opinion, de	ath occured at the	time, date e	nd place, en	d due to the	e ceuse(e)	end menner o	e stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1. H.	ms			29c. LICENSE NUI			29d. DATE	SIGNED	(Month, Day, Ye	nar)
2	11 MANE AND ADDRESS OF THE OWN	Jews 1	,			D-210			1 2	212	4145	
-	30. NAME AND ADDRESS OF PERSON WHO Michael Leathe	COMPLETED CAUSE OF DE	ATH (ITEM 27)	(Type, Print)	Wal	dorf, M	aryla	and	2060	04		
	3t, OATE FILED (Month. Day. Year)	32. REGISTRAR'S SIGN	. Wal	aori	medi	cal Pa	rk P	U.Bo	x 24	49		
	FEB 2 8 199	5 Jalia David	dear Ran	dall								



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

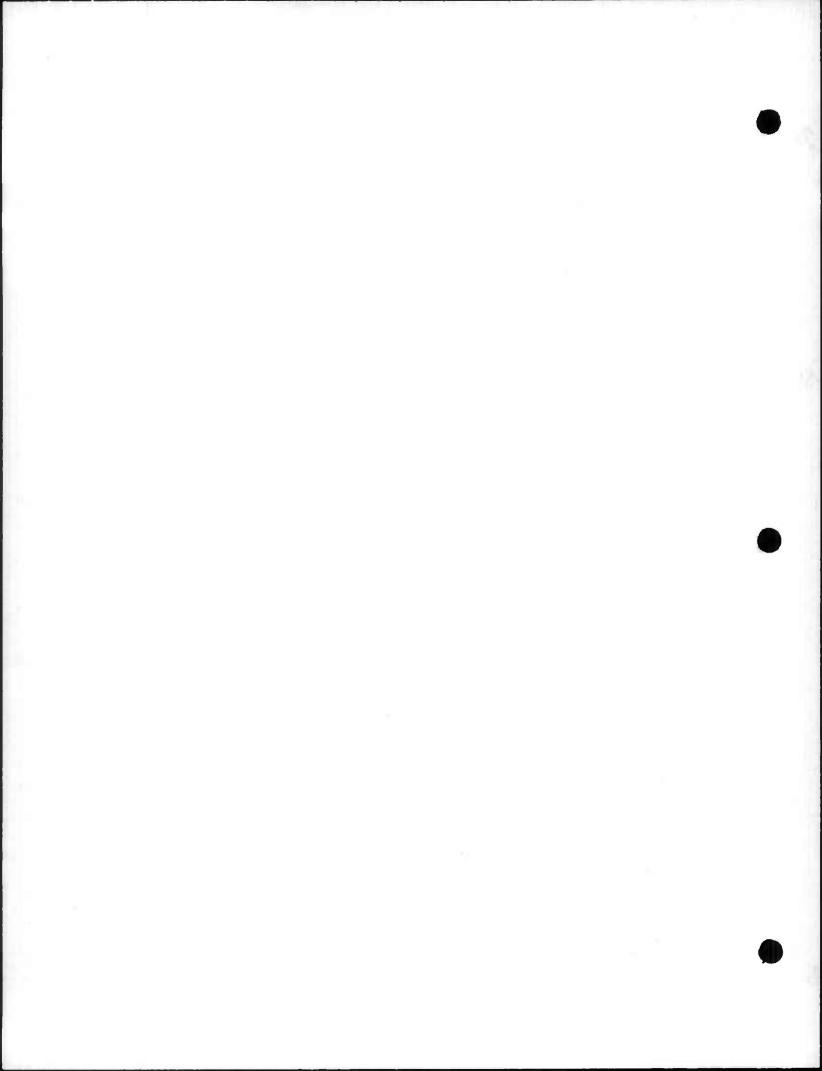
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

′ •

1 -	FOR STATE REGISTRAR	STATE OF MA			ENT OF H		MENTAL HYGIEI				
1. DI	ECEDENT'S NAME (First, Middle, L	ast)					2. DATE OF OEATH			3. TIME OF DEATH	
E	DITH ELAINE	JOHNSON							95	12:25	Рм
4. S	OCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		B. BIRTH	IPLACE (State or Fore	ign
	N/A	1 - M 2 - F	73	YRS.	VTHS DAYS	HOURS MIN.	NOV 18, 1	921	UNK	NOWN	
	FACILITY NAME (If not institution, g	live street and number)		9b	CITY, TOWN	R LOCATION OF D	EATH	9c. COUNT	TY OF O	EATH	
	ARRETT COUNTY		SPITAL	_	OAK	LAND		G.	ARRI	ETT	
10a.	SIDENCE OF DECEDENT			10c CITY TO	OWN OR LOCAT	TON					
M		GARRETT			TSVILL					10d. INSIDE CITY LIMITS?	
	STREET AND NUMBER	JIIIIII I		Oldin		ZIP CODE		T 40 - CITIZE	FN 05 Y	1 TYES 2 X N	10
1	847 OLD MEYERS	SDALE ROAD			10.00	21536		US		VHAT COUNTRY?	
7 II—	MARITAL STATUS	12. WAS DECEDENT EV	VER IN U.S. ARI	4EO			NIC ORIGIN? (Specify Vi			— American Indian	
	Never Married 2 Married	FORCES? 1 IF YES, GIVE WAR	YES 2 N		If yes, sp	ocify Cuban, Maxic	an, Puerio Ricen, etc.)	FE OF NO.	Black	, Whita, atc.	1,
- 1	Widowed 4 Divorced	ii tes, orre man	ON DATES		1 1 1 1 1 1 1	2X NO Speci	ry.		Speci	WHITE	
	15. OECEDENT'S (Specify only highest of	EOUCATION Tracks completed	16a, DEC	EDENT'S USU	IAL OCCUPATION	ON .	16b. KIND OF BU	JSINESS/INDU	STRY		
17. F	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use rel	done during mo tired.)	st or working	37				
<u> </u>	0			INVAL	ID		NE	VER WO	RKEI)	
5 17. F	FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, Middle, Maide	n Surname)			
n D	NKNOWN					UNKNOW	IN				
19a.	INFORMANT'S NAME (Type/Print)						Route Number, City or To				
	CHERYL LOCKHA	ART					EET, OAKLA			21550	
100	METHOD OF DISPOSITION Burlel 2 Cremation 3	Removal from State	1000		ISPOSITION (Na	me of		OCATION — CI			
	Donation 5 Other (Specify)	E LICENSEE	ÖÄKLÄ	ND CEM				KLAND,	MA	RYLAND	
	100 5/1	1 1			22. NAME A	ID ADDRESS OF FA	P.	.O. BO	X 24	43	
	Exalus M	Hums	M00	167	DURST	FUNERAL	HOME - OA	AKLAND	, MI	21550	
Seq if a cau	quantially list conditions, into, land, la	b. urinary t	AS A CONSEO	nfecti UENCE OF):	on					Onset and	
3 II _		d									
	erebral pasly DID TOBACCO US						PERFO	RMED?	24b.	WERE AUTOPSY FINI AWAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO	USE
₹ 25. V	MAS CASE REFERRED TO MEDICA		TO CAU	SE OF L		ACE OF DEATH (C)	123				
	EXAMINER? 1 YES 2 X NO	HOSPITAL:	2/0		THER:						
- 11	MANNER OF DEATH	26a. DATE OF INJ		26b. TIME OF			6 Other (Specify) 26d. DESCRIBE HOW	IN HIEV OCCI	IDEO		
	Natural 5 Pending	(Month, Day, 1		INJURY	WO	RK?	200. DESCRIBE NOW	mooni occo	MED		
	Accident Investigat	26a PLACE OF IN	IJURY — At hon	ne, ferm, stree			26f. LOCATION (Street	and Number o	r Rural B	loute Number	
	Homicide 6 Could not determine	building, etc.	(Specify)				City or Town, State		. reder [-vare regrinder,	
	CERTIFIER 1 X CERTIFYING P	HYSICIAN: To the best of my	knowl-de- d	th comm	Abo at		III. and the second second				
E .	(Check only one) 2 MEDICAL EXAM	MINER: On the basis of axam	ination and/or in	vestigation in	the time, data	and place, and due	to the cause(a) and me	enner as stated	d.	and manner or steel	and.
200	SIGNATURE, AND, TUT POF CERT				,						
ă II	Allahar	Maumas	-	W).	29c. LICENSE NU	MBER			(Month, Day, Year)	00-
30. N	NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE (OF DEATH ATEM	27) (Type Drin	rf)	D25759		Freb	rua	ry 21, 19	995
- 11	lter K. Nauma					MD 2157	20				
	DATE FILED (Month, Day, Year)				craent	rw 2132	20				_
	FFB 2 3 199	5 Villa Havel	war Randa	M.							
	FED 7 3 133	J Jana will									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the most law of the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAN	ID / DEPAR	RTMENT	OF H	IEALTH DEA	AND TH	MENTA		GIEN			
	1. DECEDENT'S NAME (First, Middle, Lest)						*		2. DAT	E OF O	EATH			3. TIME OF DEATH
	ROBERT	W.		JI	ERMYI	N			FEB	3 2	20 ~	199	YEAR	7:00 PM
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rrs. lest birthdey)	IF UNDER	_	IF UNDER	R 24 HRS.		E OF BIF	RTH		8. BIRTI	HPLACE (State or Foreign
	203-24-5744	1 📉 M 2 🗌 F	6	3 YRS.	MONTHS	DAYS	HOURS	MIN.		oth, Day,		1931	Count	msylvania
	9e. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY,	TOWN 0	OR LOCATI	ON OF D			. ,		NTY OF D	
DIRECTOR	MARYLAND RTE#	301			Wal	ldor	f					ch	arl	es
H	10a. STATE 10b. COUNTY	*			Y, TOWN O	R LOCAT	TION							10d. INSIDE CITY LIMITS?
		cester		Pi	tman									1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 124 Jefferson Av	enue					0807						S.A.	WHAT COUNTRY?
3	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.	S. ARMED	13. V	WAS DEC	ENDENT (OF HISPA	NIC ORIGI	IN? (Spe	cify Yes		14. RACI	E — American Indien,
	1 Never Merried 2 🕅 Merried	FORCES? 1	X YES :	2 NO	11	yee, sp	ecify Cube	m, Mexico	en, Puerlo	Rican,	atc.)		Blac	k, White, etc.
BY	3 Wildowed 4 Divorced	n/a					- <u>M</u>	Оресп	17.				Spec	White
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16	Give kind of	USUAL OC	CUPATIO	ON of world	ng	16	b. KIND	OF BUS	SINESS/INC	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	+)	F'l f'ght	Mech	ani	.C	79	F	ede	ral	Avi	atio	n
2	12			and Su					P	Admi	nis	trat	ion	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)							HER'S NA	AME (First,	Middle,	Meiden	Surneme)		
ш	John Jerm	yn							Nel	llie	Мо	rris		
0 8	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING									Code)	
F	Patricia Jermyn			124 J	effer	son	Ave	nue	- Pi	itma	n,	NJ	0807	1
	20e. METHOD OF DISPOSITION 1 □ Burial 2 🔯 Cremetton 3 □ Rem. 4 □ Donation 5 □ Other (Specify)	oval from State	20b.PL cegneler WOC	ACE AND DATE	of Disposi ther plece) remat	TION (Na	me of			Z4 [CATION -		ersey
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. N	IAME AN	D ADDRE		ACILITY					ersey
	Donald.	8. Hie	الما		1	03 1	V. St	tock	ton	St.	, E	s, P. lktor	n, MI	21921
	23. PART i. Enter the diseases, or of shock, or heart failure.	complications the	t coused th	e death. Do	not enter	the mo	de of dy	ing, auc	ch as car	rdiac o	r respi	ratory arr	rest,	Approximate
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Mun	this	PINSEQUENCE O	rjuh	is								interval Between Onset and Death
CERTIFICATION	Sequentially list conditions,	b		INSEQUENCE O										
ATI	if any, leading to immediate cause. Enter UNDERLYING	002 10	(OH AS A CO	MSEQUENCE U	-):									
윤	CAUSE (Disease or injury that initiated events	c	OR AS A CO	NSEQUENCE O	n.									
E	reaulting in death) LAST		(011 110 11 00	NO LOOLINGE OF	,,.									
핑		d												
ا بـ	PART il. Other aignificant condition	a contributing to	deeth but i	not resulting	in the unc	ierlylng	g cause (given in	Part i.	24a. V		AUTOPSY	24b	WERE AUTOPSY FINDINGS
MEDIC/										1.7	YES 2			AVAILABLE PRIOR TO COMPLETION DF CAUSE
W I										1				DF DEATH?
=	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF I	DEATH YE	SON	10 🗆	UNC	ERTAI	ΝП					With I Blie
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			PLACE OF OEA							_			
Sic	1 X YES 2 □ NO	HOSPITAL:	ER/Outpatle	nt 3 🗆 DOA	OTHER		9 5 □ Re	eldence	s Ki Oth	er (Spec	(fv) C	CENI	F.	
<u> </u>	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJI	URY AT					JURY OCC		most
ВУР	1 Netural 5 Pending	Month, D	/	- 16	30M	1 U Y	RK?	NO	C	(:	f	- /	.11	vehice
	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE O	FINJURY -	At home, farm, s		ry, office	- 6		281. LOC	CATION	(Street e	and Number	or Rural F	Route Number, *
COMPLETED	4 Homicide determined	bullaing,	enc. (Specify)						Pr	or Town	State)	1 STE	te Ro	a good to
립	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledg	e, death occurr	d at the tin	na, dete	end place,	end due	to the ce	use(e) a	nd man	ner as atat	ed. #\$	em welde RF
8	MEDICAL EXAMINE													end mailner ee stilled.
E C	29b. SIGNATURE AND TITLE OF CERTIFIER					1	29c. LICE	NSE NUI	MBER			29d DATE	FISIGNED	(Month, Day, Year)
8	Theodere l	1.11	, ,	12.				C.M						21,1995
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAU	E OF DEATH	(ITEM 27) (Type.	Print)									-1-223
	THEODONE M.	Ken				Str	eet	. Ва	alti	imo	re.	Mar	rvla	nd 21201
	31. DATE FILED (Month, Day, Year)	32/REGISTRA						, ,				.1(4)	-1 -0	21201
	FED 0 4 1995 d		or-Randa											
		MANAGE BY THE WAY												



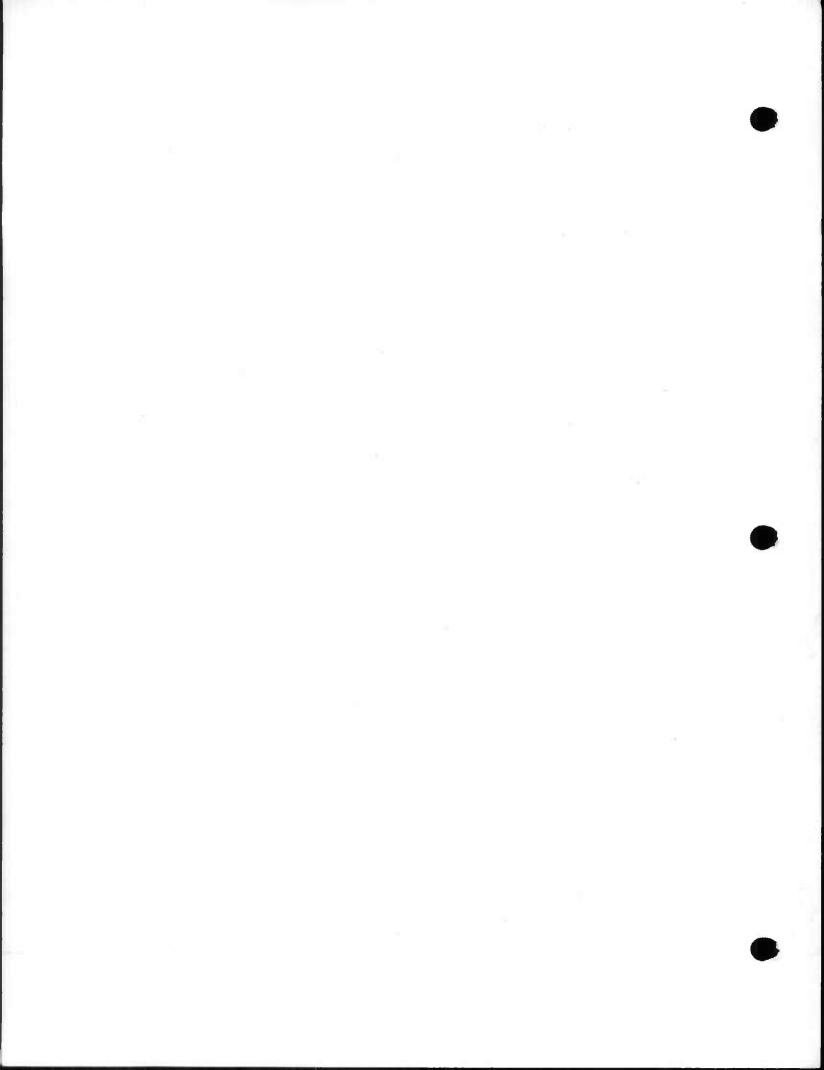
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS. P.O. ROX 68760

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IMPURIANI: I nem 28 is marked, of nem 23 shows any injury, of other traumanc event, the medical examiner must be notified at once.
IMPORTANT. II HEHE & IS HARRED, O' HEHE & STOWNS ANY HIGHTY, O' CHINEL TRAINING TO THE EXAMINET THE TOTAL OF NOTIFIED AT ONCE.

STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH AN	ID MENTAL	HYGIENE
C	ERTIFICATE	OF DEATH		BEG NO

	1 - FOR STATE REGISTRAR	ATE OF MARYLAND	DEPARTM			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Lest)			0.		2. DATE OF DEATH		3. TIME OF OEATN
ò	DAISEY MARIE			Tai	NEC	TELSRUARY	20, 199.5	
	4. SOCIAL SECURITY NUMBER 5. SET	X 6. AGE (In yrs. Ia	st birthday) #	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		THPLACE (State or Foreign
	222-26-2900 1 □ 9a. FACILITY NAME (If not institution, give street and	M 2 X F 94	YRS.	CITY TOWN C	HOURS MIN.	(Month, Day, Year) JULY 31, 1		
Œ	PENINSULA REGIONAL M			SALIS		ain	WICO	
DIRECTOR	RESIDENCE OF DECEDENT						11100	
REC	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	DELAWARE SUSSEX		SELBY	VILLE				1X YES 2 NO
AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF	WNAT COUNTRY?
FUNERAL	81 WEST CHURCH STREE	T		19	975		USA	
5		AS OECEDENT EVER IN U.S. AI	RMED	13. WAS DEC	ENDENT OF NISPAN	IC ORIGIN? (Specify Yes	or No 14, RA	CE — American Indian, ick, White, atc.
ВУ		YES, GIVE WAR OR DATES	110		2 NO Specify			ecity:
	15. DECEDENT'S EDUCATION			<u> </u>				HITE
COMPLETED	(Specify only highest grade complete	ed) (C	ECEDENT'S USU Give kind of work s. Do NOT use rel	done during mo:	N st of working	16b. KIND OF BUS	SINESS/INDUSTRY	
2	Elementary/Secondary (0-12) Colle	ge (1-4 or 5 +)	NER/OPE			AUTOMOR	ILE SAL	FC
M	17. FATNER'S NAME (First, Middle, Last)	OWI	NER/ OIL	MAION	10 MOTHERIO MAN	ME (First, Middle, Maiden		60
	ANDREW JACKSON KING				SARAH E		Sumame)	
BE	19a. INFORMANT'S NAME (Type/Print)		6 MAILING AD	DESS (Street a		oute Number, City or Town	a State 7in Code!	
2	JEAN M. COOPER					HOPVILLE,		D 21813
	20a METNOO OF DISPOSITION	201 01 105	AND DATE OF D				CATION — City or	
	1X Burial 2 Cremation 3 Ramoval fro 4 Donation 5 Other (Specify)		PVILLE				•	, MARYLAND
	21. SIGNATURE OF EUNERAL SERVICE LICENSEE	2			D ADORESS OF FAC			,
	► 1/2 0 1.17£	40		HASTIN	GS FUNER	AL HOME, S	ELBYVIL	LE, DE
\neg	23. PART I. Entar the diseasea, or complic	cations that caused the d	eath Do not a	inter the mo-	de of dulpa such	an cordina or social	rotom, ornest	1 Assessment
	anock, or neart failure. List on	ly one cause on each line	е.	avitor tira mo	se or dying, add.	r aa carorac or reapii	atory arreat,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition	WILTI SECTO	Zeno C	260	1 SASC	(- 4 0		Onset and Death
- 1	resulting in death)	OUE TO (OR AS A CONSE	OUENCE OF):	7,000,77	7/1/0	con		C121 193
z	<i>-</i> ,	OUE TO (OR AS A CONSE GRAM M	cast	C	U ROSa	229		ZARUS
임	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE OF):					
S	cause. Enter UNDERLYING CAUSE (Disease or Injury							
H	that initiated events reaulting in death) LAST	OUE TO (OR AS A CONSE	OUENCE OF):					
CERTIFICATION	d.							
AL C	PART II. Other algolificant conditions contri	ributing to death but not	resulting in th	na underlying	cause given in i	Part I. 24a. WAS AN		b. WERE AUTOPSY FINDINGS
S	the a Osmola	a Comi		2,250	les.	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Dementia					1 TYES 2	NO I	OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUT	E TO CAUSE OF DEA	TH YES		UNCERTAIN			1 YES 2 NO
Ž	25. WAS CASE REFERRED TO MEDICAL	26. PLA	CE OF DEATH (C		OTTOERITATI	1 24		
Sic		PITAL: patient 2 ER/Outpatient 3		HER: Nursing Nome	5 Residence	8 Other (Specify)		
ξl		8e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJU	JRY AT	28d. OESCRIBE HOW IN	JURY OCCUREO	
ВУ	1 Natural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ES 2 NO			
ED	_ Coold not be	Bs. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, street	, factory, office		28f. LOCATION (Street as City or Town, State)	nd Number or Rura	Routs Number,
립		the best of my knowledge, de						
COMPLET	one) 2 MEDICAL EXAMINER: On th	e basis of examination and/or	investigation, in	my opinion, de	ath occured at the f	lime, data end place, and	dus to the cause	(s) and manner ea stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER	29d. DATE SIGNE	D (Month, Day, Year)
10 B	Mon	ND			D39	313	> 2/2	21 (95
-	30. NAME AND ADDRESS OF PERSON WHO COMP	LETED CAUSE OF DEATH (ITE	M 27) (Type, Print	1)		0 0		
	MATKINS	1104 Re	with c	way,	ame	SAls 1	40 ZI	801
	31. DATE FILED (Month, Day, Year) 32	RESTRANS SIGNATURE	Carlell					
	FEB 2 7 1995	June wounder .	- Card					

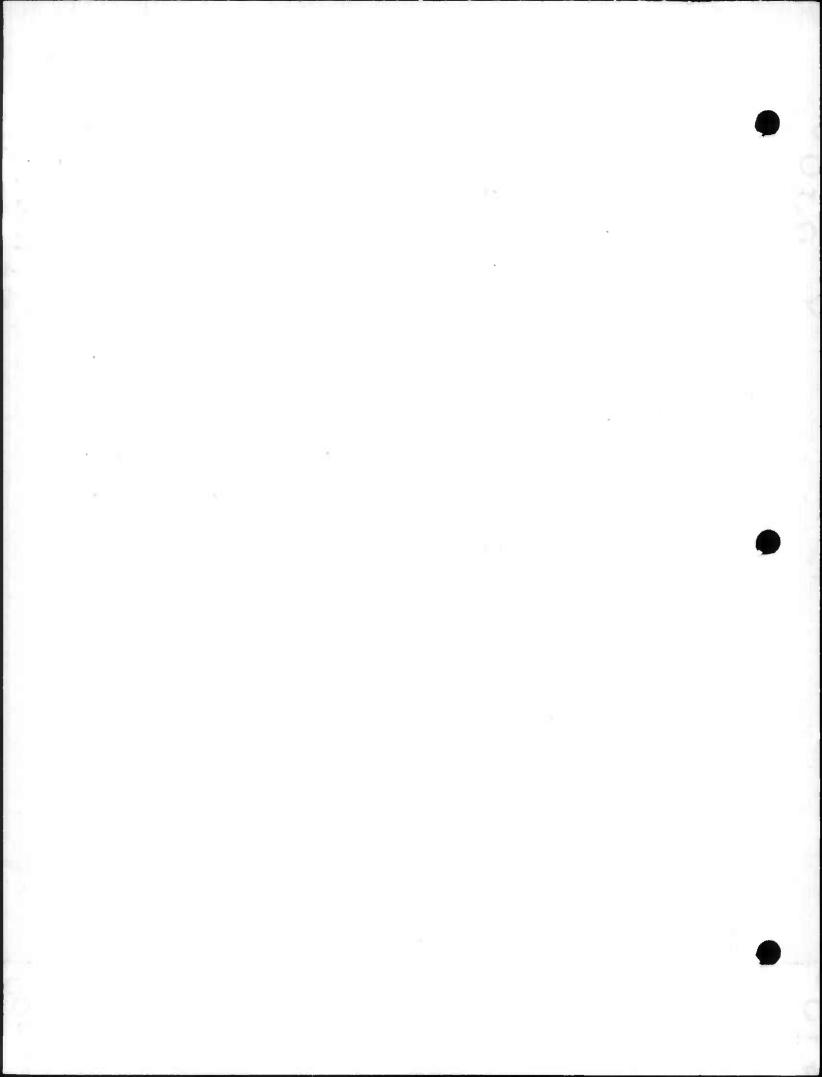


TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Hospital County after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Lest)	OMAR	BE	RNAR	ונ. מו	DNES			2. DATE OF DEATH	AY	9 YEAR	3. TIME OF DEATH 5; 30 A	
	4. SOCIAL SECURITY NUMBER	BER	5. SEX		n yrs. last b		F UNDER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIRTH			HPLACE (State or Foreign	
	@!* <u>2</u> 18-24	-4682	1 🔯 M 2 🗆 F	63			ONTHS DAY	HOURS	MIN.	(Month Dev Year) 1-9-32		SAL	ISBURY, MB	
_	9e. FACILITY NAME (If not in					9	b. CITY, TOW			EATH	9c. COL	INTY OF C		
DIRECTOR	1213		LA AVE.,				SAL	ISBUF	RY		WI	COMI	CO	
EC	10e. STATE	10b. COUNT	Υ			10c. CITY, TOWN OR LOCATION							10d, INSIDE CITY	
	MD.	WI	COMICO			SALISBURY						1 YES 2 NO		
3AL	10e. STREET AND NUMBER		1 0 01/5					101. ZIP COL			10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	12.12	10360	LA AVE.			21801						USA		
	1 Never Married 2 X	Married	12. WAS DECEDEN	YES	2 NO	NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)					or No—	Blac	E — Americen Indian, k, White, etc.	
BY	BLACK										" BLACK			
TED	(Specify onl	EDENT'S EDU y highest grade	CATION completed)		16a. DECE	EDENT'S US	UAL OCCUPA k done during etired.)	TION most of work	ing	16b. KIND OF BUS	SINESS/IN	DUSTRY	·	
L	Elementary/Secondery (t 12th	0-12)	College (1-4 or 5	+)			etired.) RE			CAMPBE	11 5	ULIB	CU	
COMPLET	17. FATHER'S NAME (First, M						(110			ME (First, Middle, Maiden		001		
BE C			PNES							MINNIE J	ONES			
TO	190. INFORMANT'S NAME (1				19b. I	MAILING AD	SS SAM	e and Number	ABOV	Ploute Number, City or Tow	n, State, Zi	p Code)	·	
	20e. METHOD OF DISPOSIT 1 Description 5 Desc	on 3 🗆 Rem	oval from State				DISPOSITION SEMEN		K			URY,		
	21. SIGNATURE OF JUNERA	L SERVICE LI	CENSEE				22. NAME	AND ADDR	ESS OF FA	OILITA		· ·	AL CHAPEL	
Щ	1213 JERSEY ROAD, SALISBURY, MD. 21801 23. PART I. Effect the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximete													
	ehbck, or h IMMEDIATE CAUSE (Fir disease or condition resulting in daeth)	aert tellure.	List Dnly one car	ned/Du ee	ch lina.					hes cerdiec or reepi		rest,	Approximete interval Batwee Onset and Daat	
CERTIFICATION	Sequantially list condit if any, leading to imme cause. Entar UNDERLY! CAUSE (Disease or inju- that initiated eventa resulting in death) LAS	dleta ING Iry	c	OR AS A										
MEDICAL C	PART II. Other significa	int condition	na contributing to	daath bu	it not ras	sulting in t	tha underly	ing cause	given in	Part I. 24a. WAS AN PERFOR 1 U YES 2	MED?	246	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
121	DID TOBACC	O USE	CONTRIBUT	E TO	CAUS	E OF	DEATH	YES [7 NO	<u>о</u> П			1 TYES 2 NO	
SICIAN:	25. WAS CASE REFERRED T	O MEDICAL	HOSPITAL:					PLACE OF	DEATH (Ch	eck only one)				
YSI	1 TYES 2 NO		1 Inputient 2		-	DOA 4			esidence	8 Other (Specify)				
ву рну	1 MATURAL 5	Pending Investigation	28a. DATE Of (Month, L	Pay, Year)		28b. TIME O	Υ	NJURY AT WORK? YES 2	□ NO	28d. DEŞCRIBE HOW II	NJURY OC	CURED		
9		Could not be determined	28e. PLACE (building,	OF INJURY - , atc. (Specif	At home	e, ferm, stre	el, factory, of	fice		281. LOCATION (Street of City or Town, State)	and Numbe	or Rural I	Route Number,	
COMPLET										to the cause(e) end mar			e) end manner ee stated.	
BE CC	29b. SIGNATURE AND TITLE	OF CERTIFIE					- · ·		ENSE NUM				(Month, Day, Year)	
오	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAU	SE OF DEAT	TH (ITEM 2	27) (Type, Pri		IV	<u> </u>	201	- /	141	147	
	31. DATE FILED DE	1° 199	Grasso	AL SIGNA	15	E		ROU	14	- Jaus	nu	ey	m	
			V											



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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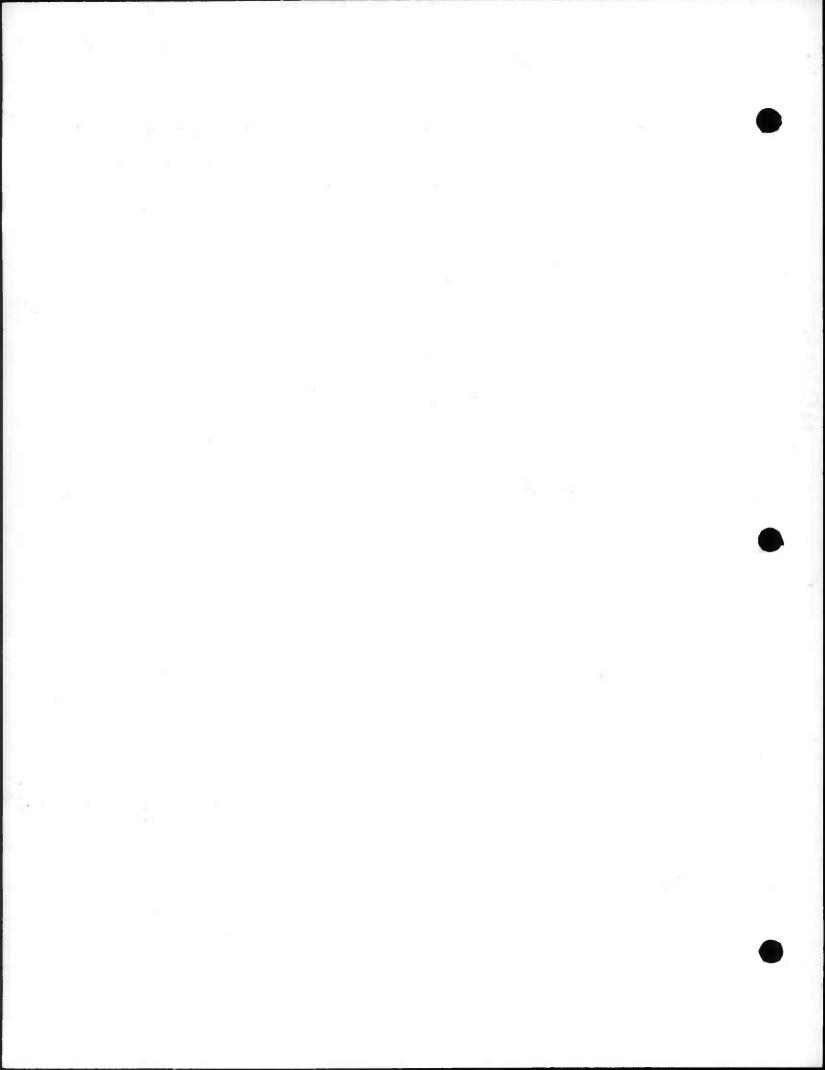
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

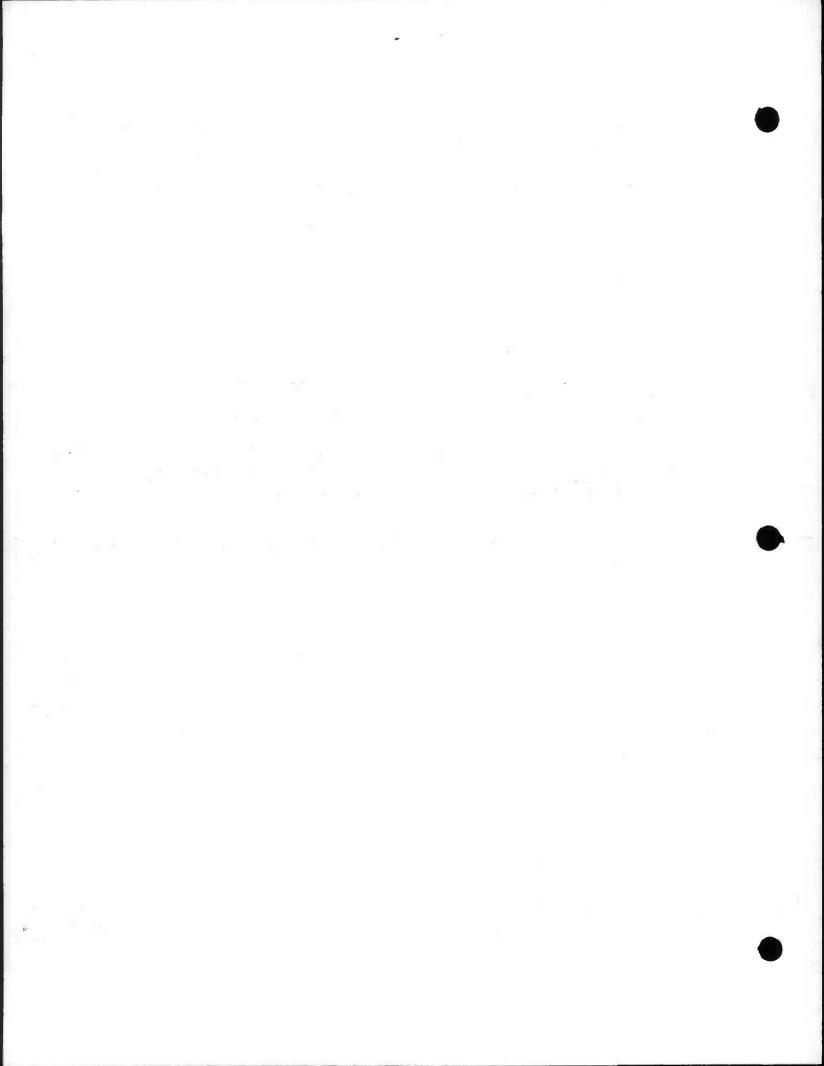
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	DECEDENT'S NAME (First, Middle, Last) EMMA TO)NA	Johnson				2	DATE OF DEATH	MY	YEAR	3. TIME OF DEATH 18 55 M		
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)			IF UNDER 24		DATE OF BIRTH	ارقا				
	212-03-4703	1 □ M 2 🙀 F	M 2 \(\overline{\overline{\pi}}\) F 76 YRS. MONTHS DAYS HOURS MIN. (MONTH, Day, Year) June 28, 19					6. BIRTHPLACE (State or Foreign Country) Maryland					
OR	9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY 9c. COUNTY OF DEATH WICCO								ICOM				
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10a. CTY, TOWN OR LOCATION												
DIRECTOR	100 GTT, 10				wn or Location uitland				10d. INSIDE CITY LIMITS? 1 (X YES 2 □ NO				
FUNERAL	10e. STREET AND NUMBER					101, ZIP CODE				ZEN OF V	WHAT COUNTRY?		
NE I	301 Hayward Ave.				21826				USA				
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				yes, spe	NDENT OF I	Maxican, P	ORIGIN? (Specify Ye warto Rican, etc.)	s or No- 14. RACE — American Indian, Black, Whila, etc. Specify: White				
	16. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	USUAL OC	CUPATION	ν		16b. KIND OF BU	SINESS/IND		ite		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of a	vork done du le retired.)	uring most	of working							
₽	17. FATHER'S NAME (First, Middle, Last)		Stampe	r						ory			
	Alfred	Johnson					renc		Shirt Factory st. Middle, Melden Surname) Hitch umber, City or Town, State, Zip Code) and, MD 21826				
3 BE	19a. INFORMANT'S NAME (Type/Print)												
2	Iona E. Sprague		622	E. Ma	ain S	St.,	Frui	tland, MI	218	26			
	20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Remaided Donation 6 Other (Specify)	oval from Stale	cometery, cremetory or o Springhill N	of DISPOSIT	TION (Nam	ne of		OATE 20c. LO					
	21. SIGNATURE OF FUNETION BERVICE LIC	ENSEE	Springhill N			ens ADDRESS	OF FACILI	2/20 H	lebror	n, Ml	D		
	16M.	Hell	ruce 1		Hol:	loway Snow	Fund	eral Home 1 Rd., Sa	alish	urv.	MD 21801		
	23. PART I Enter the disesses, or o	complications that cause	sed the death. Do r	ot enter t	the mod	e of dying	, such as	cardiac or resp	Iratory arr	est,	Approximate		
										Onset and Death			
	resulting in desth)	disease or condition resulting in desth) DUE TO (OR AS A CONSEQUENCE OF):									- unp		
_	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):												
2	CAUSE (Disease or injury	D. CHE TO COD A											
	that initiated events resulting in death) LAST	ODE TO (OH AS	S A CONSEQUENCE OF	-):									
	DART II OAN - Jarieland - Jarieland												
CAL	PART II. Other significent conditions			n the und	derlying	csuse give	en in Par	PERFOR	RMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
PHYSICIAN: MEDIC		Jackson 120 of the Colonial Co					1 U YES 2 KNO			OF DEATH?			
ž	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH YE	S 🗆 N	10 🗆	UNCER	RTAIN [5			1 TYES 2 NO		
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one)											
IXSI	1 TYES 2 KNO 27. MANNER OF CEATH	1-12 Inpetient 2 - ER/O	ng Home	ne 5 🗆 Rasidence 6 🗆 Other (Specify)									
	1 Natural 5 Pending	28a. DATE OF INJUR (Month, Day, Year		E OF 2 URY M	WOR	K?		d. DESCRIBE HOW I	NJURY OCC	UREO			
B S	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJU	JRY — At home, farm, street, factory, office			ZES 2 NO 261. LOCATION (Street		LOCATION (Street	et and Number or Rural Route Number,				
COMPLETED	4 Homicide determined	building, atc. (S)	oecny)					City or Town, State)					
2	29a. CERTIFIER (Check only	(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.											
ဂ္ဂ	one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated.										and menner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
2	12 NAME AND ADDRESS OF STREET	MO			-	D383.	35		1/16/15				
	30. NAME AND ADDRESS OF PERSON WHO		DEATH (ITEM 27) (Type,	-	14.	10	IKKIII	W ma	OIVI	1			
1	31. DATE FILEO (Month, Day, Year)	32. MEDISTRASES SA	PARTURE I	0	7.	UPPA	130/1	y mo	81001				
	FEB 21 1995	yava arus	ACH NUMBER OF										



TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 70 hours after death with the State Dent of Health and Memai Hunises notes to burial criemation or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

	REGISTRAR			CENTIFIC	CALE	F DEATH	REG. NO).				
	1. DECEDENT'S NAME (First, Mide	die, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
- 1	Etta	Eula		Jen]	kins			28, 19	95 1430 M			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign			
	216-22-6354	1 - M 2XXF	77		ONTHS DAYS		(Month, Day, Year)	- 1	Country)			
	90. FACILITY NAME (If not institution		//				April 15,		Vest Virginia			
00				- 1		OF LOCATION OF D		9c. COUNT	Y OF DEATH			
CTOR	Calvert Memori	<u>ial Hospital</u>			<u>Prince</u>	Frederic	k	Calv	rert			
<u>မ</u>	RESIDENCE OF DECED	COUNTY		10. 0171	TOWN OR LOC							
DIRE				1.0					10d. INSIDE CITY LIMITS?			
		St. Mary's		Mec	<u>hanics</u>	ville			1 TES 2 NO			
I₹	100. STREET AND NUMBER					10f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?			
FUNERAL	95 Donna Drive	5				20659		Unite	ed States			
5	11. MARITAL STATUS	12. WAS DECEDE			13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (Specify Ye		I. RACE — American Indien, Black, White, etc.			
	1 Never Merried 2 Marr		MAR OR DATES	XHO		specify Cuben, Mexico ES 2XXNO Speci	en, Puerto Rican, etc.)					
B	3 X Widowed 4 Divorced				'''	ANIO Open	7.		White			
8	15. DECEDEN	IT'S EDUCATION	16a.	DECEDENT'S U	SUAL OCCUPAT	TION	16b, KIND OF BU	ISINESS/INDUS				
	Elementary/Secondary (0-12)	college (1-4 or 5	+)	(Give kind of wo life. Do NOT use	rk done during i retired.)	most of working						
၂로	8	0	·	Cosme	tician		Dri	g Stor	92			
once. COMPL	17. FATHER'S NAME (First, Middle,	Lest)				18. MOTHER'S NA	ME (First, Middle, Maider	-				
8	Samuel Martin	Mauk					Rebecca E					
B B	19a. INFORMANT'S NAME (Type/P)			19h MAILING A	OODESS /Stan		Route Number, City or Tox					
TO BE	Guy T. Jenkins		1									
8							nicsville,					
15	20g, METHOD OF DISPOSITION 1 IX Buriel 2 Cremation 3	☐ Removal from State	20b. PLAG	CEAND DATE OF	DISPOSITION (Neme of	OATE 20c. LO	OCATION — CIT	y or Town, State			
E	4 Donation S Other (Spec		_ Mt.	Pleasa	nt Chui	rch Cem.	3+4-95 Cum	berlan	d, Maryland			
=	MgB 11 Mark &		*****		THE LI	AND ADDRESS OF FA	DAI HOME	TMC				
medical examiner must be	White has	arohawn !	400053	h a new and the near the new trees								
8	23. PART I. Enter the diseas	tes or complications the	t coursed the	dooth Do no	P.U.D	OX 136, M	ALDUKF, MA	KYLANL	20604			
Del	ahock, or heart	fallure. List only one ca	use on sach I	ina.	t enter tha n	lode or dying, aud	n as cerdiac or reap	iratory arres	t, Approximata interval Between			
the	IMMEDIATE CAUSE (Final disease or condition											
	resulting in death) a. Cardio respiratory forest											
3 8		DUE TO	(OR AS A CON	SEQUENCE OF):	/							
휥	Sequentially list conditions. In Matastatic Adenocarcinoma											
E E	resulting in death) a. COPCIO PAS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediata causa. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
E 3	CAUSE (Disease or Injury	CAUSE (Disease or Injury										
4 5	that initiated events DDE 10 (OR AS A CONSEQUENCE OF):											
	resulting in death) LAST											
2 194	PART II Other elegifleest a		decab by a									
rs amy inju	PART II. Other algnificant co	onalibne contributing to	deeth but no	it resulting in	the underlyi	ng ceuse given in	Part I. 24a. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
							1 _ YES :	2XXNO	COMPLETION OF CAUSE			
69	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
SICIAN	25. WAS CASE REFERRED TO ME			ACE OF DEATH								
Item	EXAMINER? 1 TES 2 NO	HOSPITAL:	☐ ER/Outpatient		OTHER:							
5 0 >	27. MANNER OF DEATH	26e. DATE OF		26b. TIME		JURY AT						
-	1 Setural 5 Pendi	(Month, L	Day, Year)	INJUI	RY W	VORK?	26d. DESCRIBE HOW	INJURY OCCUP	REO			
	launa'	tigation				YES 2 NO						
mag M		I 26e, PLACE (home, farm, atr	eet, factory, off	Ice	26f. LOCATION (Street City or Town, State		Rural Route Number,				
	3 Suicide 6 Could	not be building.	eres (openny)	4 Homicide determined								
28 Is	3 Suicide 6 Could	not be building.	The (Opening)									
tem 28 is	3 Suicide 6 Could 4 Homicide determ	mined building.		death occurred	st the time, da	te end place, end due	to the cause(e) end ma	nner as stated.				
If Item 28 Is	3 Suicide 4 Homicide 6 Could deterr 29e. CERTIFIER (Check only Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on	mined building	my knowledge,						aute(s) and manner as stated.			
If Item 28 Is	3 Suicide 4 Homicide 6 Could detern 29e. CERTIFIER (Check only 1 CERTIFYIN	IG PHYSICIAN: To the best of a	my knowledge,			death occursed at the	Time, date and place, or	nd dive to the c	suse(x) and manner as stated.			
If Item 28 Is	3 Suicide 4 Homicide 6 Could deterr 29e. CERTIFIER (Check only Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on	IG PHYSICIAN: To the best of a	my knowledge,				Time, date and place, or	nd dive to the c	SUBSECTION OF THE STATE OF THE			
PORTANT: If item 28 is BE COMPLETED	3 Suicide 4 Homicide 6 Could detern 29e. CERTIFIER (Check only) 2 MEDICAL 29b. SIGHATURE AND TITLE OF C	IN POLICIAN: To the best of EXAMINER: On the best of a	my knowledge,	or Investigation,	In my opinion,	death occursed at the	Time, date and place, or	nd dive to the c				
PORTANT: If item 28 is BE COMPLETED	3 Suicide 4 Homicide 6 Could detern 29e. CERTIFIER (Check only 2 MEDICAL ! 39b. SIGNATURE AND TITLE OF C	IN DO BOUND BUILDING	my knowledge,	TEM 27) (Type, P.	in my optesion,	29c. LICENSE NUI	Time, date and place, or MBER	29d. DATE S	1GNED (Month, Day, Year) 3/1/9(
PORTANT: If Item 28 is BE COMPLETED	3 Suicide 4 Homicide 6 Could detern 29e. CERTIFIER (Check only 2 MEDICAL ! 39b. SIGNATURE AND TITLE OF C	IN DO BOUND BUILDING	my knowledge,	TEM 27) (Type, P.	in my optesion,	29c. LICENSE NUI	Time, date and place, or MBER	29d. DATE S	1GNED (Month, Day, Year) 3/1/9(
PORTANT: If item 28 is BE COMPLETED	3 Suicide 4 Homicide 6 Could detern 29e. CERTIFIER (Check only 2 MEDICAL ! 39b. SIGNATURE AND TITLE OF C	In the beautiful building, mined building, min	my knowledge,	TEM 27) (Type, P	in my optesion,	29c. LICENSE NUI	Time, date and place, or MBER	29d. DATE S				



BALTIMORE, MARYLAND 21215-0020

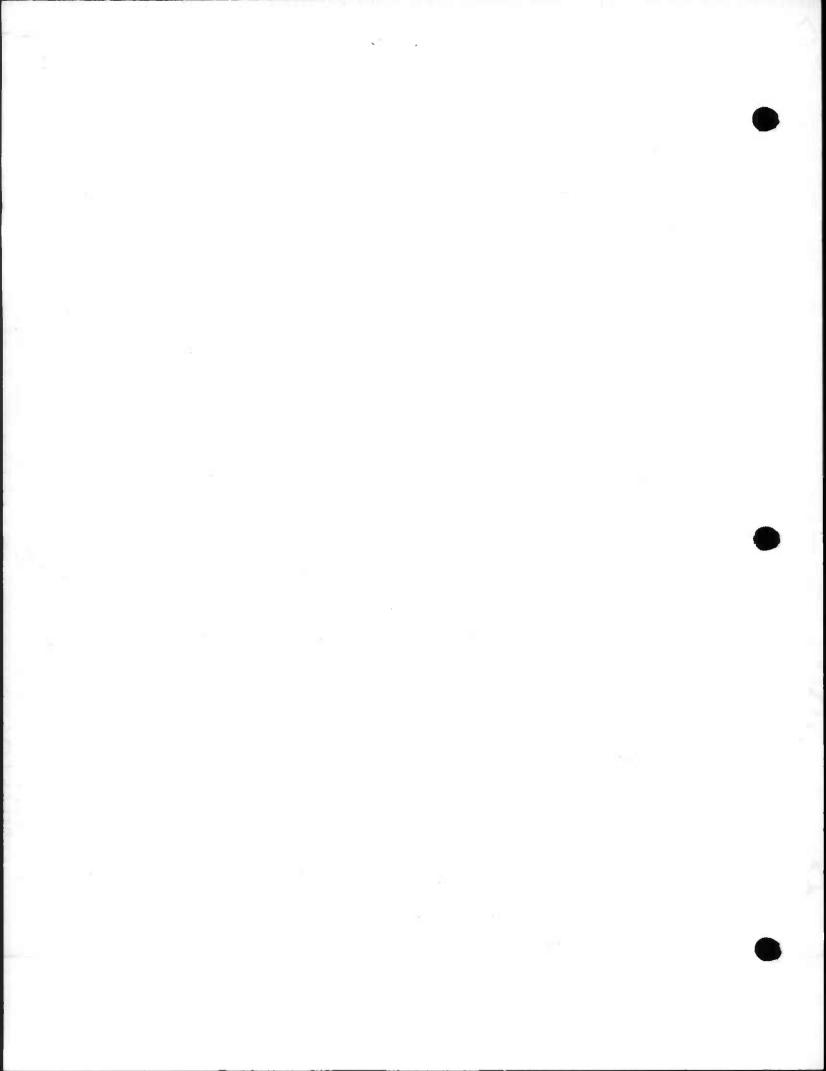
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found of the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY		TMENT OF		MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)	R	Jone			2. DATE OF DEATH DATE OF THE D		3. TIME OF DEATH 705 A M		
	4. SOCIAL SECURITY NUMBER 214-16-7423	5. SEX 6. AGE	(In yrs. lest birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS	7. DATE OF BIRTN (Month, Day, Year) JULY 13, 1	6. BIRT				
TOR	98. FACILITY NAME (If not institution, give str DORCHESTER GENER RESIDENCE OF DECEMENT	,		96. CITY, TOWN	OR LOCATION OF D		9c. COUNTY OF DORCHE	HTAB		
DIRECTOR	10a. STATE 10b. COUNTY	OLINE		Y, TOWN OR LOCA			10d. INSIDE CITY LIMITS?			
FUNERAL	10e. STREET AND NUMBER P.O. BOX 453	32112			OI. ZIP CODE		10g. CITIZEN OF	1 ☐ YES 2 X NO		
BY	11. MARITAL STATUS 1 A Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? TYTY YES IF YES, GIVE WAR OR I	2 NO	If yes, s	CENDENT OF HISPA	NIC ORIGIN? (Specify Yes an, Puarto Rican, atc.)	or No 14. RAC Blac Spec	E — American Indian, k, White, etc.		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) Callege (1-4 or 5 +)	life. Do NOT us	vork done during n e retired.)	ost of working	16b. KIND OF BUS	SINESS/INDUSTRY			
COMP	7 th 17. FATHER'S NAME (First, Middle, Lest)		FORK L	IFT DRIV	18. MOTHER'S N	AME (First, Middle, Maiden	SK& SON			
TO BE	SAMUEL E. JONES 190. INFORMANT'S NAME (Type/Print) IOLA JONES				and Number or Rural	R. GREEN Aoute Number, City or Town				
	20s. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State 20	6 PLACEAND DATEC	E DISPOSITION //	leave of	DATE 20c. LOC	CATION City of To	Ctete		
	1 XBurial 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERANS CEM. FEB.17, 1995 BEULAH, MD. 22. NAME AND ADDRESS OF FACILITY BENNIE SMITH FUNERAL SERVICES P. O. BOX 1687, EASTON, MD. 21601									
CERTIFICATION	23. PART F Enter tha diseases, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, above, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause gives in Part I. 24a. WASARATOPBY PERSONNED? 1 YES 2 DO 1 VES 2 DO 1 VES 2 DO 1 VES 2 DO 1 VES 2 DO 1 VES 2 DO									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	(ERT) HOSPUNC: OTHER:								
> 1	27. MANNER OF DERTH	26s. DATE OF INJURY (Month, Day, Year)	26b. TIME	COF 29c, IN	NE 5 Nesidence JURY AT DRK7 YES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW IN	HUMY OCCURED			
TED B	2 Accident Investigation 3 Statcide 6 Could not be 4 Homicide determinad	28e. PLACE OF INJURY building, etc. (Spe	26e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Spocity)			281. LOCATION (Smeet and Number or Rural Route Number, City or Town, State)				
TO BE COMPLETED		Vashon	CATH (1988 27) (7)04	n, In my opinion,		time, data and place, and				
FFB 1 7 1995 July Davidson Raydoll								200		



BALTIMORE, MARYLAND 21215-0020	24 nours after death. Page 6 may be retained by the hospital or attending physician.	r filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BAL	24 nours after deal	filled in by the fun
		- 12

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

									0 0 1 0 0 0
	FOR STATE REGISTRAR	STATE OF MARY			F HEALTH A		ENTAL HYGIEN	Ε	
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF DEATH		3. TIME OF DEATH
	PEARL JU	HNS					MONTH DA	49	5 // Q. A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	GE (In yrs. lest birthday)	IF UNDER 1 YE	-		7. DATE OF BIRTH		BIRTHPLACE (State or Foreign Country)
	213 18 00091	1 M 2 F	76 YRS.	MONTHS DA	YS HOURS	MIN.	11115/18	5	MARYLAND
	9a. FACILITY NAME (If not institution, give street	at and number)		96. CITY, TO	MN OR LOCATION	N OF DEAT	тн		Y OF DEATH
9	MOUND BI	Ya		CAME	RIDGE			100	RCHESTER
2	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY		100 00	Y, TOWN OR L	DOI TION				
DIRECTOR		HESTER			3810	20			10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	HESTER		ta L	10f. ZIP CODE			10m CITIZE	1 YES 2 NO
FUNERAL	520 GLENBURN AVE				2161	1 2			
13		12. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS			ORIGIN? (Specify Yes	US.	A. RACE — American Indian,
	1 Never Married 2 Married	FORCES? 1 YE	ES 2 V NO	If yes		, Mexican,	Puerto Rican, etc.)	G 1.0_ 1.	Black, White, etc.
B	3 Widowed 4 Divorced			1 '0	res 2 Mil No	орвину.			Specify: BLACK
品	15. DECEDENT'S EDUCAT (Specify only highest grade co	FION impleted)	16a. DECEDENT'S	USUAL OCCUI	PATION g most of working		16b. KIND OF BUS	INESS/INDUS	STRY
9		College (1-4 or 5+)	IHa. Do NOT u	se retired.)	y moot or monany				
COMPLET	10th		DOMES	TIC			DOMEST		
	17. FATHER'S NAME (First, Middle, Last)				110000100		E (First, Middle, Maiden	Sumame)	
B	PETER JOHNS 190. INFORMANT'S NAME (Type/Print)						LA JOHNS		
2	RUBY REDD						ute Number, City or Town		
8	20a. METHOD OF DISPOSITION					N ST			PA. 19141
	1 X Burial 2 Cremation 3 Remove 4 Donation 6 Other (Specify)		20b. PLACE AND DATE	ther placa)	•		l .	:ATION — CR	ly or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	WASHINGT		ETERY E AND ADDRESS	FEB.		_HURL(OCK, MD.
	1 /3 /						FUNERAL	SERVI	CES
5	1.200			P	.O. BOX	168	7. EASTON	. MD.	21601
	23. PART i. Enter the diseases, or cor shock, or heart fellure. List	nplications that caus st only one ceuse or	sed the death. Do n each line.	not enter the	mode of dyin	g, such	as cardiac or respi	ratory arres	Approximate Interval Between
	iMMEDIATE CAUSE (Final disease or condition	0-1	2.0						Onset and Death
Í	resulting in death)	DUE TO JOB A	S A CONSEQUENCE O	n.					DO YN
-		0 4120	L_	·).					10 14.1
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE O	f):					10 423
3	cause. Enter UNDERLYING	OBC							20 cm
E E	CAUSE (Disease or injury that initiated events	DUE TO (QR A	S A CONSEQUENCE O	F):					a to
EH	resulting in death) LAST								
O	PART II. Other significent conditions	contributing to deat	h but not regulting	In the under	hdan anuan al	un la Di			
MEDICAL		remaining to doct	Tot not recuting	in the dilder	Aud cease &	voli ili ra	ert I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
	-						1 🗆 YES 2.	EL MO	OF DEATH?
							-		1 TYES 2 THO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			2	8. PLACE OF DE	ATU Charl	t anti-anti-		
	EXAMINER?	IOSPITAL:	adoutions 2 [] DOS	OTHER:					
H X	27. MANNER OF DEATH	26a. DATE OF INJUR			INJURY AT		Other (Specify)	LIURY OCCU	RED
	1 Natural 5 Pending	(Month, Day, Year	r) IN	JURY	WORK?	NO			
D BY	2 Accident investigation 3 Suicide 6 Could not be	28e. PLACE OF INJU	IRY — At home, farm,	street, factory,	office	2	281. LOCATION (Street a	and Number or	Rural Route Number,
» I W	4 Homicide determined	building, etc. (S	респу)				City or Town, State)		
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	N: To the best of my kn	owledge, death occur	ed at the time.	date and place.	and due to	the cause(s) and men	ner as stated	
COMPLET									cause(a) and manner as stated,
U U	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICEN				SIGNED (Month, Day, Year)
8	Mr 12 of Al	,			1)1	MU	1	D 2	19195

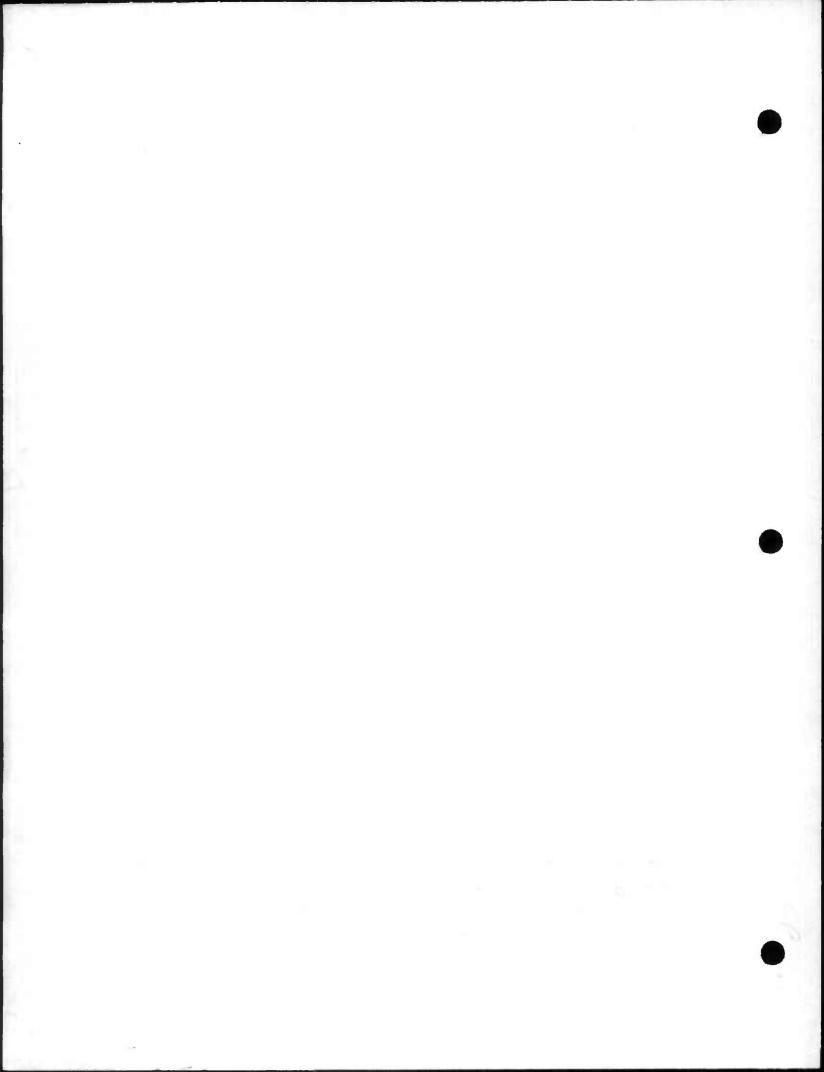
32. REGISTRAN'S SIGNATURE
JEWA DEWILLEN RENdell

31. DATE FILED (Month, Day, Year)
FEB 1 7 1995

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표	포	fled
2	2	8
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reta	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reta. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st

								2	0	07864
	1 - STATE REGISTRAR	STATE OF MA	RYLAND / DEPAI CERTIF	RTMENT OF I	HEALTH AND I		HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Las	()				2. DATE OF	DEATN		3	. TIME OF DEATN
		Astrid	E. Jensen			Febru		25. l	995	9:45 A
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTN ey, Ybar)		8. BIRTHPL Country)	ACE (State or Foreign
	217-88-0991	1 🗆 M 2 💢 F	97 YRS.			Oct.	23,	1897		mark
œ	9a. FACILITY NAME (If not institution, give				OR LOCATION OF DE	ATH			NTY OF DEA	
5	Circle Manor Nur	rsing Home		Kensin	gton			Мо	ntgom	ery
DIRECTOR	10a. STATE 10b. COUN	ıτγ	10c. Cr	TY, TOWN OR LOCA	TION		-		1	Od. INSIDE CITY
		gomery	P	otomac					1	LIMITS?
3AL	10e. STREET AND NUMBER				f. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
FUNERAL	9817 Brookford F				20854				ted S	tates
F	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	YES 2 NO	13. WAS DEC	CENDENT OF NISPAN pecify Cuben, Mexicar	IC ORIGIN? (S	specify Ye	a or No-	14. RACE - Black, V	- American Indian, White, atc.
В	3 💢 Widowed 4 🗌 Divorced	IF YES, GIVE WAR	OR DATES "	1 TYES	S 2 NO Specify	:			Specify:	hite
0	15. DECEDENT'S Et (Specify only highest gra	DUCATION	16a. DECEDENT	USUAL OCCUPATE	ON	16b. KJI	ND OF BU	SINESS/IND		IIITE
LETEI	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	work done during mo use retired.)	ost of working					
COMPL	12	- 1400 11 10	Homer	maker			0wn	Home		
္ပ	17. FATHER'S NAME (First, Middle, Last)	5 7 1/ 5 .			18. MOTNER'S NAM			Surname)		
BE	Rikkardt Somme	erfeldt-Pet			Anna					
9					and Number or Rural R	loute Number,	City or Tow	rn, State, Zip	Code)	
	Roland W. Kinney Same as 10 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State									
	1 Durial 2 🖟 Cremation 3 Re 4 Donation 6 Other (Specify)	moval from State	cemetery, cremetory or c Chesapeak	other place)			Re 14	tevili	la M	aryland
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE /		22 NAME A	NO ADDRESS OF EAC	WI ATV				ar y railu
	> Ellon	W. K	000	карр	Funeral	Servi	ces,	P. A		
	23. PART i. Enter the diseases, or	r complications that co	aused the death. Do	not anter the mo	Gist Aven	UE, 5	TTA61	retory arr	ing, i	Approximate
	shock, or heart feliure iMMEDIATE CAUSE (Finsi	. List only one cause	on each line.		or cynig, casi	· •• oardioc	ОГТОВР	natory arr	oot,	Interval Between
	disease or condition resulting in death)	Cerebral	Vascular	Accident	_					Onset and Dea
	resuring in dazun		AS A CONSEQUENCE O							l day
N	Sequentially list conditions,	Hyperter								
ATIC	if any, leading to immediate cause. Enter UNDERLYING		AS A CONSEQUENCE O	F):						
FIC	CAUSE (Disease or Injury that initiated events	e Asthma	AS A CONSEQUENCE O	F)·						
ERTIFICATION	resulting in death) LAST		us Syndrom							į
O										1
SAL	PART li. Other significent condition	ons contributing to de-	eth but not resulting	in the undarlying	g ceuse given in F	Part i, 24	PERFOR	AUTOPSY		ERE AUTOPSY FINDING: WILABLE PRIOR TO
Ď						_ 1	YES 2	X) NO		OMPLETION OF CAUSE F DEATH?
Σ	DID TORACCO LISE CON	TRIBLITE TO CALL	T OF DEATH W			_			1	☐ YES 2 X NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUS		TN (Check only one)	UNCERTAIN					
SIC	EXAMINER?	HOSPITAL:		QTHER:	· · · · · · · · · · · · · · · · · · ·		dia.			
Η	27. MANNER OF DEATN	28a. DATE OF INJ	URY 28b. TIN	E OF 28c, INJ		28d. DESCRI		NJURY OCC	URED	
ВУ Б	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, 1	ear) in.		YES 2 NO					
	3 Suicide 6 Could not be	28e. PLACE OF IN	JURY — At home, term, (Specify)	street, tectory, offic	•	28I. LOCATIO	N (Street a	and Number	or Rural Rout	e Number,
ETE	4 Homicide detarmined					0.1y 0. 10	, State)			
7		SICIAN: To the best of my								
= 1	2 MEDICAL EXAMIN	NER: On the beels of exami	nation and/or investigation	on, in my opinion, d	leath occured at the t	ime, date end	place, en	d due to the	cause(a) ar	nd manner as stated.
SOME		4 ^			29c. LICENSE NUM	BER		29d. DATE	SIGNED (M	anth Day Mart
	296. SIGHATURE AND TITLE OF CERTIFI	5 0 /2								
TO BE COMPLETED	(Jyllo /	Sch	2		D 26520)		₩Feb	ruary	25, 1995
	30. NAME AND ADMIESS OF PERSON W	HO COMPLETED CAUSE O	F DEATH (ITEM 27) (Type	, Print)			1.			
BE	(Jyllo /	THO COMPLETED CAUSE OF, M. D.,	15215 Sha	. Print) dy Grove			le,			



TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

M	L
I.I	-

Amended.	# 99	2/2	8/95	- 1	1 K	ST ,	mon to	100	Dera	0	our	740	0 0
1 - FOR STATE REGISTRAR	STATE	OF MAR	TLANU /	UEPAK	IM	ENI UF H	EALTH AND	MENT	AL HYGIEN	E		1	
1. DECEDENT'S NAME (First, Mic	idle, Last)	<u></u>				112 01	DEATH	2. DAT	E OF DEATH			3. TIME OF DEA	ATH
JO	ELLYN		GRO	OMS.	- J	OHNSO	N	FE.	B. 21	19	YEAR	5:34	Рм
4. SOCIAL SECURITY NUMBER	5. SEX	8. AC	GE (In yrs. les			INDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH		8. BIRTHP	LACE (State or F	
263-90-7457	1 🗌 M 2	ĽX F	47	YRS.	MON	THE DAYS	HOURS MIN.		nth, Day, Year) 7 • 28 • 1	947	Flor		
9a. FACILITY NAME (If_not institu		iber)			96.	CITY, TOWN D	R LOCATION OF D			_	NTY DF DE		
12509 GRAN	IT RIDGE	DRIN	/E		N	ОВТН	POTOMA	C		MON	TGOM	FDV	
RESIDENCE OF DECE	ENT	DICE	711							PION	I GOM.	LKI	
	b. COUNTY			10c. CITY		WN OR LOCAT						od. INSIDE CIT	Υ
Maryland	Montgor	nery			1	worth .	Potomac				1	YES 2	KND
100. STREET AND NUMBER	D' 7 D					101.	ZIP CODE					AT COUNTRY?	1
12509 Granite							2087	8		Un	ited	States	
11. MARITAL STATUS 1 Never Married 2 Mar	12. WAS DI FORCE	S? 1 Y	R IN U.S. AR	MED ID		13. WAS DECI	ENDENT OF HISPA city Cuban, Maxic	NIC DRIG	IN? (Specify Yes	or No-	14. RACE -	- American Ind White, atc.	llen,
3 Widowed 4 Divorced	IF VES	GIVE WAR OF	DATES		- 1		2 NO Speci		, , , , , , , , , , , , , , , , , , , ,		Specify:		
15 DECEDE	NT'S EDUCATION		44. 05	00001710	1							Whi	te
(Specify only hig	hest grade completed)		(G	ive kind of w Do NOT us	vork a	AL OCCUPATION fone during most	n it of working	16	b. KIND OF BUS	SINESS/INI	DUSTRY		
Elementary/Secondary (0-12)	College (1	4 or 5+)				ookkeej	per		Depart	ment	Stor	e	
17. FATHER'S NAME (First, Middle							18. MOTHER'S NA			Surname)			
-	M. Grooms	5		_					ckson				
19a. INFORMANT'S NAME (Type/							nd Number or Aural 1, Grant						
Joseph M. Gro										329			
20a. METHOD OF DISPOSITION XIX Burial 2 Cremation : 4 Donation 6 Other (Spe	3 G Removal from Stocify)	eta	cemetery, cre Flori	metory or other	her pl	orial (me of 2/25/9 Gardens	i	Roc	kled		lorida	
21. SIGNATURE OF FUNERAL SE	RVICE LICENSEE			-	П	22. NAME AN	D ADDRESS OF FA	CILITY F	Robert	A. P	umphr	ey Fune	eral
1 Juch 10	(7. K.	tta	моо	240	1		Bethesda nsin Ave						F 0 1
23. PART I. Enter the disea	sea, or complication	na that ceu	sed the da	ath. Do n	ot e	nter the mod	le of dylng, aud	h as ca	rdiac or reapi	ratory an	reat.	Approxim	
shock, or haart IMMEDIATE CAUSE (Final	fallure. List only o	na cause or	aach line							7,		Interval E	Batween
disease or condition	UND	ETERMIN	ED									Orialet art	o Daeth
reaulting in death)	a	DUE TO (OR A	S A CONSEC	UENCE OF):							-	
				2001-00-1	,							İ	
Sequentially list conditions if any, leading to immediate		DUE TO (OR A	S A CONSEC	DUENCE OF):							i	
cause. Enter UNDERLYING	` .												
CAUSE (Disease or Injury that initiated eventa		DUE TO (DR A	S A CONSEC	UENCE OF):							1	
resulting in deeth) LAST	d.												
PART II. Other electrices a	andlikana anadalbud											1	
PART II. Other algnificant of	contribut	ing to deatr	but not n	eaulting is	n the	underlying	cause given in	Part I.	24a. WAS AN PERFOR			YERE AUTOPSY F	
									1 TYES 2	□ NO		OMPLETION DF	CAUSE
											1	YES 2	ND
DID TOBACCO USE	CONTRIBUTE TO	O CAUSE	OF DEA	TH YE	SE		UNCERTAI	N \square					
25. WAS CASE REFERRED TO ME EXAMINER?	DICAL HOSPITA	M -	28. PLAC	E DF DEAT		eck only one)							
1 YES 2 NO		nt 2 RER/O	utpatient 3	□ DOA		HER: Nursing Home	5 - Residence	6 🗆 Oth	er (Specify)				
27. MANNER OF DEATH	/4.	ATE OF INJUR	-1	266. TIME		28c. INJU		26d. DE	SCRIBE HOW II	JURY OC	CURED		
1 Netural 5 Pend 2 Accident Inves	ling itigation	VD: 2/2	1/95	1:30	Ρ!		ES 2 XXND	UNK	NOWN				
3 Suicide 6XX Coul	o not be	LACE OF INJU uliding, etc. (S)UND: H(pecify)	me, farm, at	treet,	tactory, offica		281. LO	CATION (Street a or Town, State)	12509 MONTG	GRANI GRANI	RIDGE	DR.
29a. CERTIFIER	NC DHVOICIAN, T- 11	had of a .	4.4										
	NG PHYSICIAN: To the EXAMINER: On the ba												
X===			, or without I	verigatiol	, eft (пу ориноп, ае	en occured at the	ume, det	a and place, and	aue to th	e cause(a) a	ng manner aa 1	Rated.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

29c. LICENSE NUMBER

O.C.M.E.

29d. DATE SIGNED (Month, Day, Year) FEB.22,1995

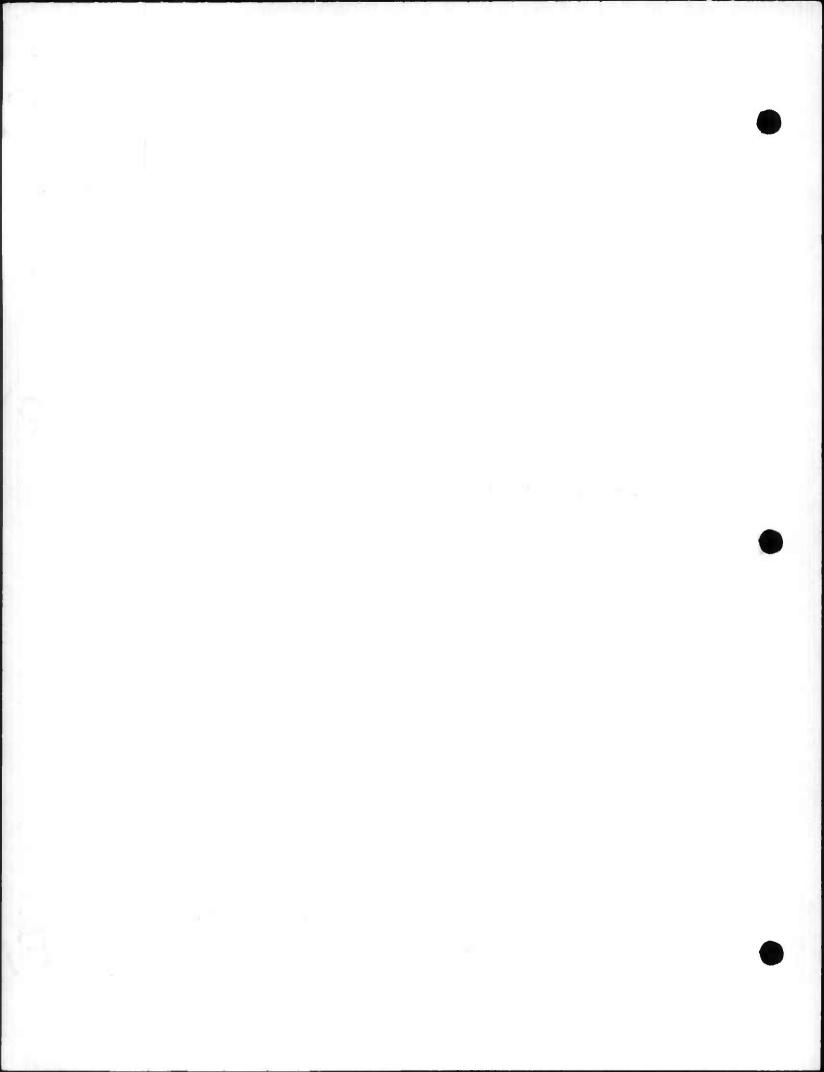
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

David

Penn Street, Baltimore, Maryland 21201

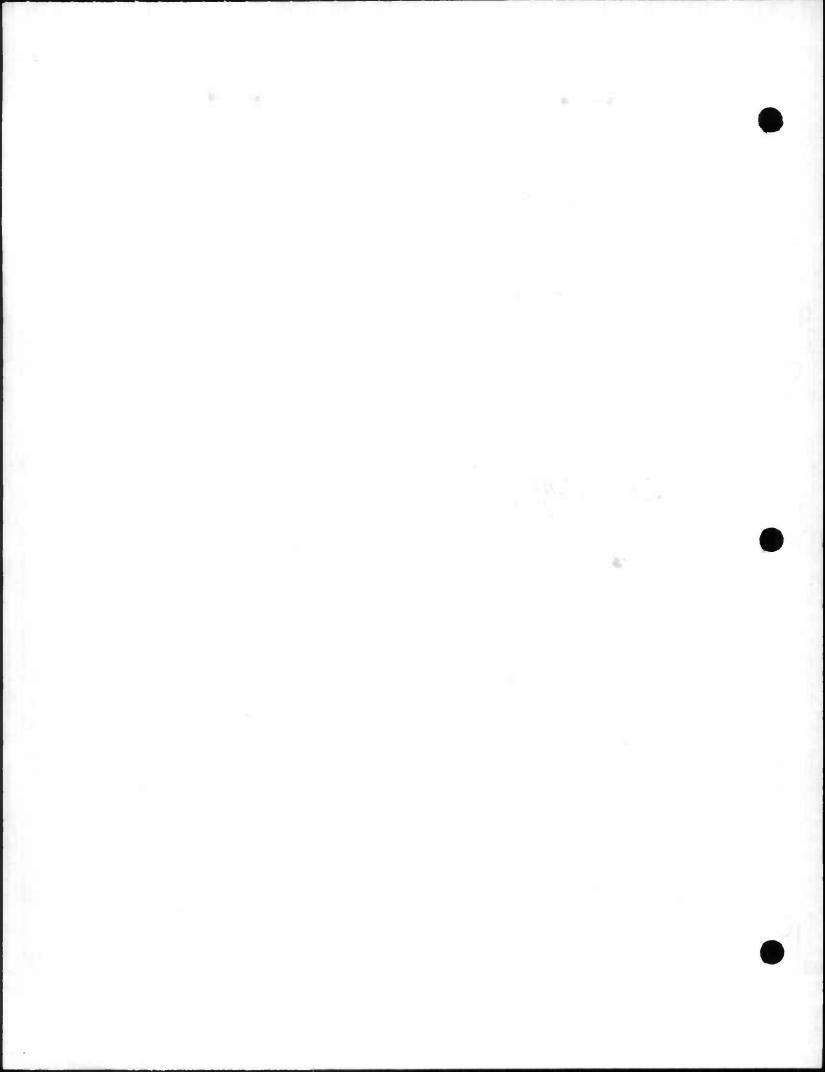
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF I	HEALTH AND	MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	20				2. DATE	OF DEATH			3. TIME OF DEATH	
	ELEANOR	P.	JENK	INS		FEBR	and made		YEAR 95	06251	
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH		. BIRTHP	LACE (State or Foreign	
	230-38-4092	1 □ M 2 🔀 F 6		DAYS	WOOKS MIN.		6, 19	933		ginia	
	9e. FACILITY NAME (If not institution, give st			9b. CITY, TOWN	OR LOCATION OF I	DEATH		9c. COUNT	Y OF DE	ATH	
₹	Suburban	Hospital		Bethe	esda			Mon	tgon	nery	
DIRECTOR	10a. STATE 10b. COUNTY	1	10c. CITY,	TOWN OR LOCA	TION					10d. INSIDE CITY LIMITS?	
		son	Ne	ellysfor	rd					1 ☐ YES 2 🔀 NO	
ERAL	10e. STREET AND NUMBER			10	r. ZIP CODE			10g. CITIZE	N OF W	IAT COUNTRY?	
N	3 Hooded Warbler				22958					States	
FUN	1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	CENDENT OF HISPA Decify Cuban, Maxic	an, Puerto I	l? (Specify Ye: Rican, etc.)	or No—	I. RACE - Black,	American Indian, White, atc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WAR ON DA	1125	1 U YES	3 2 🔀 NO Spec	tty:			Specify	White	
3	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S U	SUAL OCCUPATION OF	ON and working	16b	KIND OF BU	SINESS/INDU	STRY	MILLE	
COMPLEIED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)	out or working						
1	1.2 17. FATHER'S NAME (First, Middle, Last)		Homemak	er	1		Own I			17	
- 1	, , , , , , , , , , , , , , , , , , , ,				18. MOTHER'S N			Surname)			
2	Lilburn B. Porte 19a. INFORMANT'S NAME (Types/Print)	rileid	10h MAII ING A	DOBESS (Sheet	Mabe and Number or Rura	1 Boy		A			
2	J. William Jenkin	C							,	- 22056	
1	20g, METHOD OF DISPOSITION		PLACE AND DATE OF	DISPOSITION	ler Lane	, Nel		CATION - CH			
	1 🖾 Burial 2 🗆 Cremation 3 🗆 Remo	oval from State ceme	PLACE AND DATE OF etery, cremetory or other the of He	er plece) Mai	rch 1, 1	995					
I Gate of heaven cemetery ISilver										, Maryrai	
21. SIGNATURE OF FUNERAL SERVICE DCENSEE M00831 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-28											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch ea cardiec or respiratory arresphance, or hear failure. List only one cause on each line.											
	shock, or heart failure/I IMMEDIATE CAUSE (Final	List only one cause on ea	ich line.		,,			atory and	,	Approximata interval Betwee Onset and Dea	
	disease or condition resulting in death)	Con	1		ran)	3				el a co	
1	resulting in death)	DUE TO (OR AS A	CONSEDUENCE OF	2	Chor					- troge	
	Sequentially list conditions,	Conforal	ed /2	plue	ale	4				elay	
	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):								
CHILICALION	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE DF):								
	resulting in death) LAST		1501150405							İ	
ا د	DARK II Oaker de Misse a se Misse										
ţ	Metatati	s contributing to death bu	it not reaulting in	the underlyin	g ceuse given ir	n Part i.	24a. WAS AN PERFOR		1	VERE AUTOPSY FINDING	
	_ work	· Corcor	שרינ			—	1 TYES	NO		COMPLETION OF CAUSE OF DEATH?	
Ε	DID TORACCO LICE CONTR	NIDITE TO CALICE OF	DEATH VEC	CI NO E	7	-			1	☐ YES 2 X NO	
AN	DID TOBACCO USE CONTR		6. PLACE OF DEATH	(Check only one)	3 4.144	N KI					
SICIAN	EXAMINER?	HOSPITAL:		OTHER:		- Cl					
	27. MANNER OF DEATH	26a. DATE DF INJURY	28b. TIME	OF 28c. INJ	10 5 Realdence			NJURY OCCU	RED		
	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJUI		YES 2 ND						
	3 Suicide 6 Could not be	28s. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (and Number or	Rural Ros	ute Number,	
	4 Homicide determined	5 10 1 (5,000)	""			City	or Town, State)				
	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle	idge, death occurred	at the time, date	and place, and du	n to the cau	se(a) and mar	ner as stated		-	
COMPL		R: On the beals of examination								and menner as atated.	
u	296. SIGNATURE AND TITLE OF CERTIFIER		11.0		29c. LICENSE NU					Aonth, Day, Year)	
۱۱ ۱	tre ou	alm	TD		0205	78		>	1/2-	1/95	
2	NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, P	Joel	Shulma	n, M.	D	,			
	1110 orlande	syclain his	1. Be	Chord	me	2	08/	7			
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	LED ~ 1999										



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permit. Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

31. DATE FILED (Month, Day, Year)

MAR 0 6 1995

32. REGISTRAR'S SIGNATURE

Julia Davelson Revolate

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN DAY YEAR Joseph CHAPMAN Jordan March 1995 10:16 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign (Month, Day, Year) AUG. 18,1920 7 4 YRS. DAYS 1 M 2 F 217-14-7736 MARYLAND 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATN DIRECTOR Physicians Memorial Hospital La Plata Charles 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND CHARLES BEL ALTON 1 YES 2XX NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? NONE - GENERAL DELIVERY 20611 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify: В 3 Widowed 4 Divorced BLACK 1941-1945 ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) UNKNOWN LABORER PRIVATE 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) FRANK JORDAN EMMA DAY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HELEN TURNER #909 LAUREL LANE, LA PLATA, MARYLAND 20646 20e_METNOD OF DISPOSITION
1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State OATE 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of MARYLAND VETERAN CEMETERY 3/7/95 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) MANUFACTURE OF FUNERAL SERVICE LICENSES THORNTON FUNERAL HOME, P.A. phason DIA C. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640 23. PART i. Enter the diseesee, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory erreet, shock, or heert fellure. List only one ceuee on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Death diseese or condition wer resuiting In death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate . Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF) thet initieted events recuiting in death) LAST PART II. Other eignificant conditions contributing to deeth but not reculting in the underlying cause given in Pert I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATN? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL:
1 X Inpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 TES 2 NO 4 ☐ Nursing Nome 5 ☐ Rasidence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d, OESCRIBE NOW INJURY OCCURED 1 Naturel 5 Pending Investigation м 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, tarm, street, factory, offica building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Nomicide 29a, CERTIFIER 1 💢 CERTIFYING PNYSICIAN: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) ▶ 3-2 -95 D-02975 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 11345 Pembrooke Square, Suite 104 Daniel M. Waldorf, Maryland 20603 Howell

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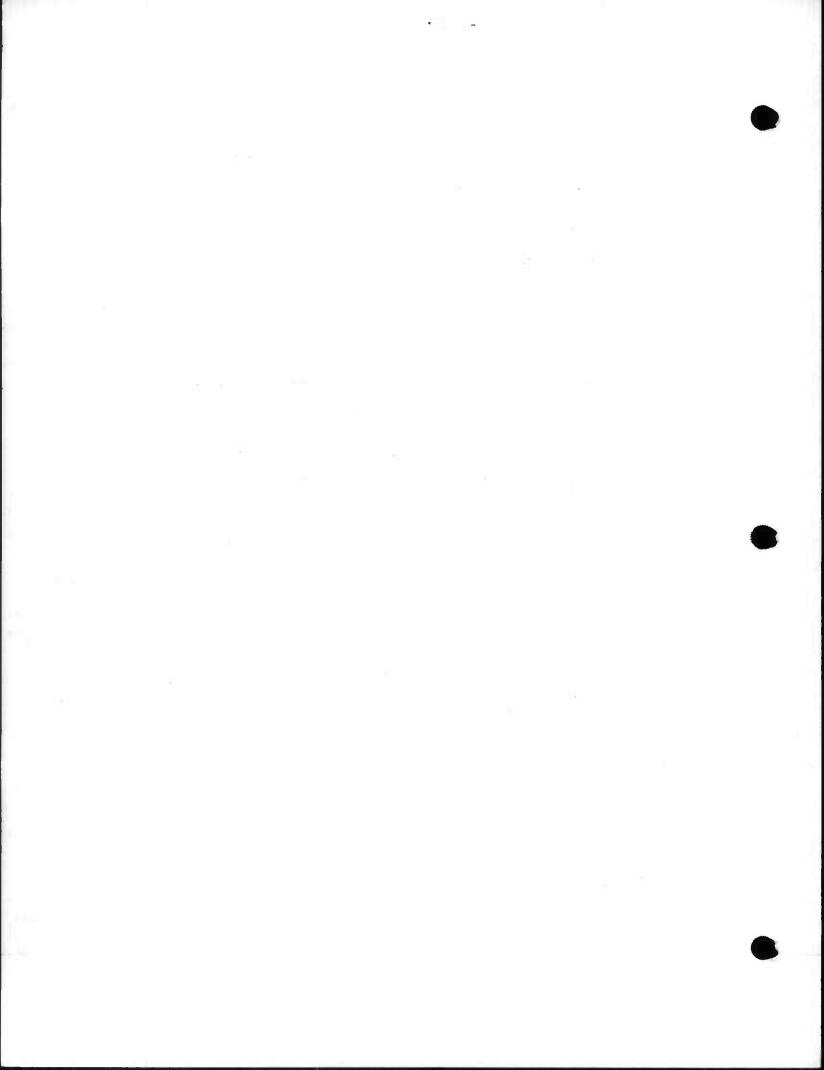
FOR STATE REGISTRAR

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DIVISION	

- [- 1	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF MONTH	DEATH	NY.	YEAR	3. TIME OF DEATH	
		ELLIS E			OHN:	SON			MARCH	1 3	1.	1995	8:15 PM	
		4. SOCIAL SECURITY NUMBER		. AGE (In yrs. las		F UNDER 1 YEA		F UNDER 24 HRS.	7. DATE OF (Month, D			8. BIRTH	8. BIRTHPLACE (State or Foreign Country)	
		577 - 14 - 9612	1 💢 M 2 🗌 F	83	YRS.	ONTHS DAY	rs H	OURS MIN.	July		911	Maryland		
		9e. FACILITY NAME (If not institution, give si			9	b. CITY, TOW	VN OR L	OCATION OF I				INTY OF D	EATH	
	8	Howard County Gen	eral Hosp	ital		Columb	bia				Howard			
	5	RESIDENCE OF DECEDENT								•				
	DIRECTOR	10e. STATE 10b. COUNTY				TOWN OR LO	CATION	1					10d, INSIDE CITY LIMITS?	
		Maryland Howar	<u>a</u>		Hig	hland							1 YES 2 NO	
	⊼ੂ∣	10e. STREET AND NUMBER						P CODE			10g. CIT USA		HAT COUNTRY?	
	9	6828 Mink Hollow			20777									
	FUNERAL	11. MARITAL STATUS 1 Never Merried 2 X Merried	12. WAS DECEDENT E FORCES? 1	YES 2 女	U.S. ARMED 13. WAS DECENDENT OF HISP 2 NO 14 yee, specify Cuben, Mexi				PANIC ORIGIN? (Specify Yee or No — 14. RACI				— American Indian, t, White, etc.	
	B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES						,		Specia		
	- 1	15. DECEDENT'S EDU	CATION	100 00	8e. DECEDENT'S USUAL OCCUPATION								nite	
		(Specify only highest grade	(G	live kind of wor Do NOT use i	k done during	most o	f working	16b. KII	ND OF BUS	SINESS/IN	DUSTRY			
	ا ۳	Grade 8		lkman	otri 00.7			Dai	1017					
Ce.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)	****	LIMITALI		-	MOTHERIO	AME (First, Midd	_					
at o		Horace Johnson					- 1		ine Lei					
60	BE	19e. INFORMANT'S NAME (Type/Print)	-	10	h MAII INC AI	DDBESS (State			Route Number,					
examiner must be notified at once.	임	Doris Johnson											d 20777	
pe pe		20g, METHOD OF DISPOSITION	-	6828 Mink Hollow Road, Highland, Marylan 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or To										
net		1 Buriel 2 Cremetion 3 Remo	oval from State	cemetery, cre	ACE AND DATE OF DISPOSITION (Name of ry, crematory or other place)							-		
- L	1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	I Unio	on Cemetery 3/6 Burtonsville,							, maryrand		
Ē		-6/11-11/)//			Dona	ald	son Fu	neral F	lome,	P.A			
× L	_	KIN II	abilly.										nd 20707	
g		23. PART I. Enter the diseases, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, abock, or heert fallure. List only one cause on each line. Approximate intervel Batween												
Ē		IMMEDIATE CAUSE (Final											Onsat and Daath	
=		disease or condition resulting in daeth) . End stage disabed conducting opportunity										urs		
or other traumatic event, the medical	DUE TO (OR AS A CONSEQUENCE OF):										1			
tic	Z	disease or condition resulting in daeth) e. End Stare disabed cordiony opolicy DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										415		
Emn	CERTIFICATION													
12	<u>ა</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury												
oth	늗	that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
0		resulting in death) LAST												
Jan J	H	PART ii. Other algniticant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
my i	EDICAL	Rayal Cell Care										1	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
hows any injury,		R - P-oll	11 - 1	2 1	20-			anger (-	YES 2	KWO		OF DEATH?	
C/3	Σ	Benen Prostate DID TOBACCO USE CONTI	DIBLITETO CALL	CE OF DE	TLA VEC	D NO			N. et				1 TES 2 NO	
23	¥	25. WAS CASE REFERRED TO MEDICAL	CIBUTE TO CAU		E OF DEATH			UNCERTA	IN PA					
Herr	PHYSICIAN	EXAMINER?	HOSPITAL:			THER:								
ō	¥	27. MANNER OF DEATH	1 Inpetient 2 E	R/Outpatient 3	28b. TIME C		injury		S Other (S)		u II IBV AA	CHEC		
rked		Natural 5 Pending	(Month, Day,		INJUR	Υ	WORK?	2 NO	28d, DESCRI	ec now II	AJUNT OC	CONED		
E	B	2 Accident Investigation 3 Suicide	28e. PLACE OF II	NJURY — At ho	me, term stre			10	28t, LOCATIO	W /Steam -	and North-	r or Ormal O	Inside Mismber	
28 is marked, or item		S Could not be determined	building, etc	. (Specify)		, нассоту, с			City or To	own, State)	www.numbe	or Muhii A	oute number,	
E	COMPLETED	290. CERTIFIER		_			_		<u> </u>	_				
=		(Check only CERTIFYING PHYSIC												
IMPORTANT: If Item	8	one) 2 MEDICAL EXAMINE	H: On the beele of exem	nination end/or	investigation,	in my opinio	n, death	occured at th	e time, date end	piece, en	d due to ti	he ceuse(e)	end menner ee stated,	
	BE	296. SIGNATURE AND WILL OF CERTIFIER	1=				29	c. LICENSE NU			29d. DAT	E SIGNED	(Month, Day, Year)	
퇿	0	1641as						D 363	577			3/3/	95	
	-	The Life of the Li												
		MARCINE A	TLBORNO		ND	34	448	W.lke	suff en	#	108	BAR	PSSIS ON OT	
		31. DATE FILED (Month, Day, Year) 32 AREGISTRAR'S SIGNATURE												
		MAR 0 7 1995	Julia d'hu	when han	dall									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

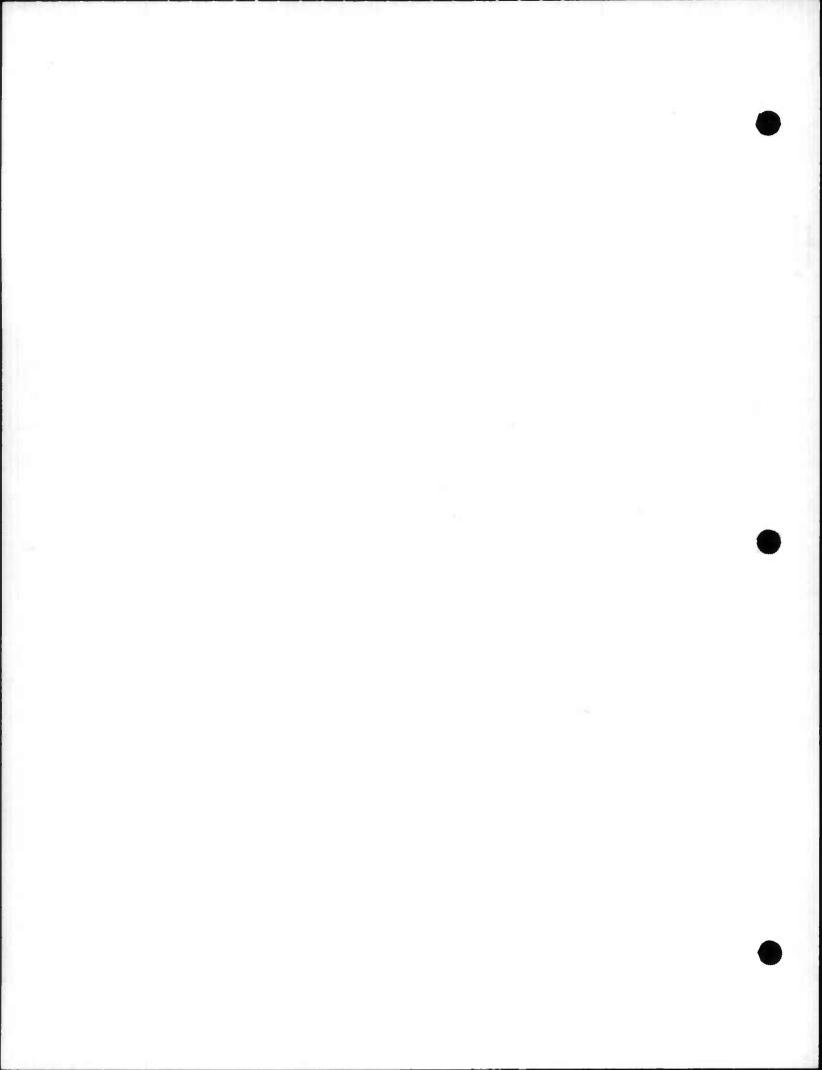


DIVISION OF VITAL RECORDS, P.O. BOX 68769

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

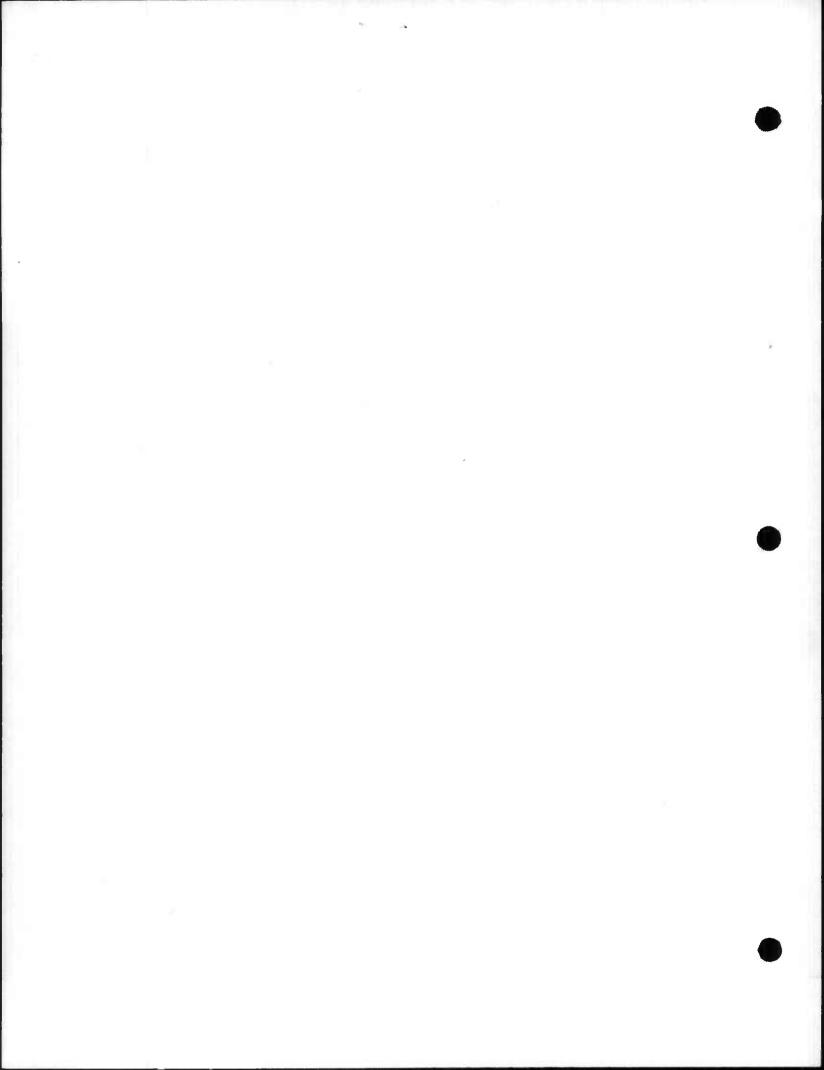
15	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH													
- 2			RONAL	D DAL	3	JE	WELL.			Februa:	DAY	YEAR		
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	R 1 YEAR	IF UNDER	1 24 HRS.	7. DATE OF BIRTH		8. BIRTHE	7:45 a M	
	212-24-05	57	1 -M 2 -F	66	YRS.	MONTHS	DAYS	HOURS	MIN.	Jun 12,		Country	MD	
_	9a. FACILITY NAME (If not in					9b. CITY	r, TOWN	OR LOCATI	ON OF DE			UNTY OF DE		
DIRECTOR	Memorial I		al			(Cumb	erla	nd		A	llega	ny	
E I	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCA	ION					10d. INSIDE CITY	
	MD	Alle	gany		Co	Corriganville						ĺ	LIMITS?	
IAL	10a. STREET AND NUMBER												ZEN OF WHAT COUNTRY?	
FUNERAL	P.O. Box 2					21524			US	USA				
5	11. MARITAL STATUS 1 Never Married 2 🔀	T EVER IN U.S. AR	MED 10			DECENDENT OF HISPANIC ORIGIN? (Specify Yes specify Cuban, Maxican, Puerto Rican, etc.)				or No— 14. RACE — American Indian, Black, White, etc.				
B	3 Widowed 4 Divo	YES 2 N	ES 1 ☐ YES 2 XNO Specify:						'	Specify:				
	15. DECEOENT'S EDUCATION				CEDENT'S	USUAL O	CCUPATIO	ON		16b, KIND OF	BIJSINESS/II		hite	
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				ive kind of v Do NOT us	work done se retired.)	during mo	st of working	ng			10001111		
COMPLETED						ed Ma	achi	nist		Rai	lroad			
ខ្ច	17. FATHER'S NAME (First, Middle, Last)							18. MOT	HER'S NAM	AE (First, Middle, Ma	den Surname)			
BE	Lester 3									(Hendri				
2	19e. INFORMANT'S NAME (7	100								oute Number, City or				
	Charlotte 20a. METHOD OF DISPOSIT		zell		_				rigan	ville, M		524		
1	1 X Buriel 2 Crematic	n 3 🗆 Remo	oval from State	cemetery, cre	matani as a	there mineral			a a a ba		LOCATION -	- City or Tow	rn, Stata	
3	21. SIGNATURE OF FUNERA		ENSEE /	I Rest.	awii				SS OF FAC		davare	, 110		
	> fan	es 1	1 XIC	arpl	IL.	. Scarpelli Funeral Home Cumberland, MD 21502								
	23 PART I Finter the diseases or complications that agreed the death of the second than the se												Approximata	
	IMMEDIATE CAUSE (Fir			-						interval Between Onset and Death				
	disease or condition resulting in death)	→ ,	. Ite	PAT	IC FAILURE						luces			
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<u> </u>	Sequentially list conditi	one,	DUE TO	(OR AS A CONSEC	TIC FAILURE INSEQUENCE OF): CELL CA LUNG INSEQUENCE OF):							4 MO.		
3	if sny, lesding to imme- cause. Enter UNDERLY! CAUSE (Disease or inju	NG				,							į	
CERTIFICATION	that initiated events		DUE TO	(OR AS A CONSEC	DUENCE OF	F):								
	resulting in deeth) LAST													
- 14	PART ii. Other significa	nt condition	contributing to	deeth but not n	esulting I	n the ur	nderlylng	cause	given in i		AN AUTOPSY		WERE AUTOPSY FINDINGS	
EDICAL					P					1	PERFORMED? AMAILABLE PRIOR COMPLETION OF C			
	-											- 1	OF DEATH? 1 YES 2 NO	
z I	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🖭	NO [UNC	ERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL -	HOSPITAL:		E OF DEAT	H (Check								
1 X	1 YES 2 NAME OF OBJUST 27. MANNER OF OBJUST 1		1 Inpatient 2 28a. OATE OF		DOA 28b. TIM	4 🗆 Nun	sing Hom		eldence l	Other (Specify)				
BY P	1 Natural 5	Pending Investigation	(Month, D	ay, Ybar)		URY M	-	PK? PK? PES 2	NO	28d. OEȘCRIBE HO	W INJURY O	CCURED		
	3 Suicide 8	Could not be determined	28e. PLACE O building,	F INJURY — At horetc. (Specify)	me, term, s	treet, fact	ory, office			281. LOCATION (Str. City or Town, St	et and Numbe	er of Rural Ro	ute Number,	
	29a. CERTIFIER													
COMPLET							to the cause(a) and lime, data and place			and manner as stated.				
u II	296. SIGNATURE AND TITLE					NSE NUM			TE SIGNED (
2	www	an	a	m IV	VD			D	2540	6	•	2/2	7/95	
-	30. NAME AND ADDRESS OF										-			
Dr. William Lamm-47 Virginia Avenue-Cumberland, MD 21502														
FEB 2 8 1995														



FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN YEAR **GLENN** LAMONT **JONES** FEB. 24 1995 5:15 PM 4 SOCIAL SECURITY NUMBER 5. SEX July15, 1969 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 127-08-4266 1 X M 2 | F DAYS HOURS MD 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 415 OAKINGTON ROAD Havre de Grace HARFORD Pages 1, 2, 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Harford Havre de Grace permit. 1 YES 2XXNO 10a, STREET AND NUMBER FUNERAL STREE 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21008-21078 attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit mtal Hygiene prior to burial, cremation, or removal. 818 Ontario zsST USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puarto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced BY Specify: Black WW II COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY BUTTLING Elementary/Secondary (0-12) College (1-4 or 5+) Auto. Worker DRIVER Auto. Manufacturer 12 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnama) Ernest JONES notified at 8 Edna Dennison 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 818 Ontario St. Hayre de Grace, MD Michelle Jones Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 Donetion 5 Other (Specify) St. James Cem. Havre de Grace, MD 3-6 examiner 21. BIGNATURE OF PUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Beard Funeral Home Havre de Grace, MD event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Gunshet Wounds of Head Multiple Guns DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) executed with other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 been signed by the atten of. of Health and Mental i PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any YES 2 NO YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: s certificate has be th the State Dept. AM. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER:
4 □ Nursing Home 5 □ Residence 8 💢 Other (Specify) IN A FIELD 1 YES 2 NO 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. DATE OF INJURY (Month) Day, Year) 27. MANNER OF DEATH 26b. TIME OF INJUST M marked, 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c 1 Natural 5 Pending subject shot 1 YES 2 NO В 2-24-95 OR ATTENDING After 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number of Rural Route, Number of City or Town, State) 415 Oakingfrn Kd
Harfard C. MD 28 is 6 Could not be determined COMPLETED DIRECTOR: Nours after field 4 Homicide Found If item 29a. CERTIFIER (Check only one)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. HOSPITAL FUNERAL D TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: II basis of axamination and/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) luste O.C.M.E. FEB. 25, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) Davelson Roydall 0 6 1995



the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal.

Pages 1, 2, 3 should

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TO THE HOSPITAL O TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If Ite

OR ATTENDING PHYSICIAN: The law

CERTIFICATION

PHYSICIAN: MEDICAL

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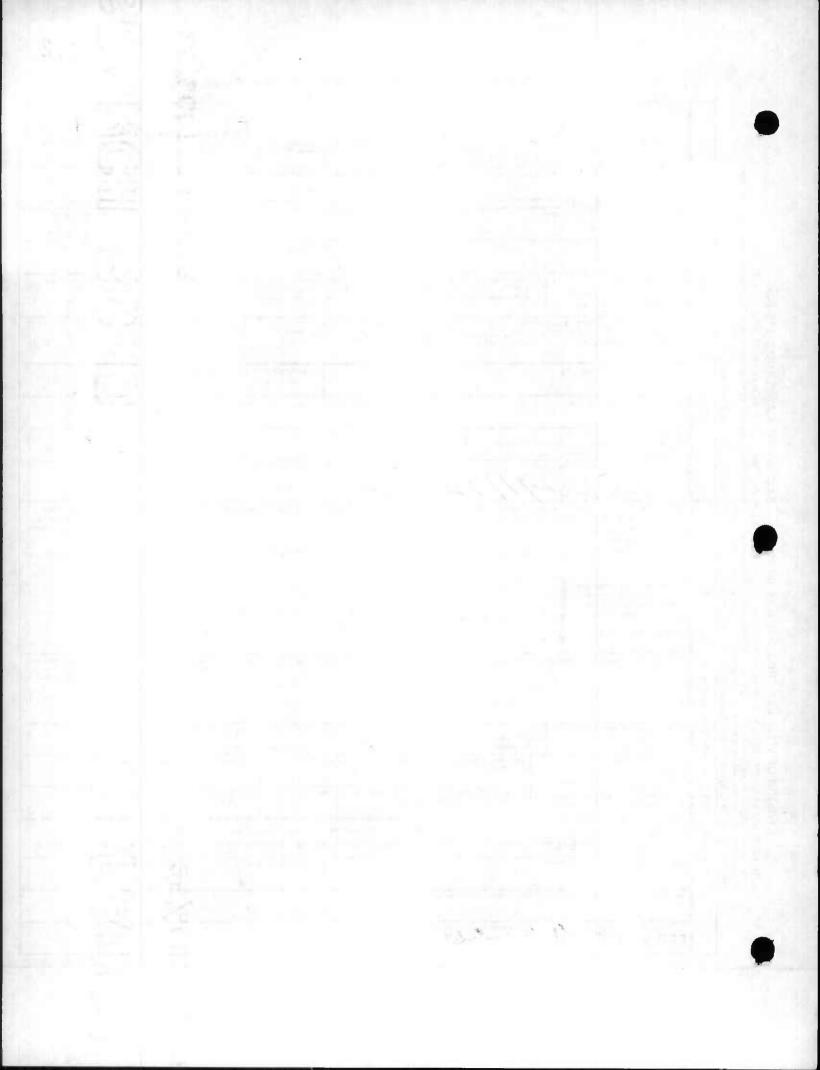
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Gloria Marie Kruest February 95 12:03 PM 7. DATE OF BIRTH (Month, Day, Year)
Jan. 26, 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 191-20-2742 70 1 M 2 KF VBS 1925 West Virginia 9a. FACILITY NAME (If not Institution, give street and number) FALSTON GEN. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Bel Air Convalescent Center Hospital Bel Air Harford RESIDENCE OF DECEDENT 10e. STATE 10b COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Pennsylvania Beaver Freedom 1 - YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1205 Thorne Street 15042 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yea, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify Specify: white 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Custodian Freedom School District 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) George H. Heinz Margaret M. Luft 190. INFORMANT'S NAME MADGELENE ANN THOMAS 196. MAILING ADDRESS KATHLEEN Rural Route Number, City or Town, State, Zip Code) Madgelena Thomas 2908 Kathern Drive, Forest Hill, Maryland 21050 20a. METNOD OF DISPOSITION 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 1 | Burlet 2 | Cremation 3 | Removal from State
4 | Donation 5 X Other (Specify) | Entomoment Svivania Hills Mausoleum 2/24/95 Rochester, PA 22. NAME AND ADDRESS OF FACILITY
HOWARD K. McComas III Funeral Home, P.A. 21. SIGNATURE OF MUNERAL SERVICE LICENSEE 1317 Cokesbury Road, Abingdon, Md. 23. PART I. Enter the diseasea, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition Myo cand resulting in death) DUE TO (OR AS A CONSEQUENCE OF srona Sequentially list conditions, if any, leading to immediate Dealettes cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART ii. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 - YES 2 NO 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 1 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 TYES 2 NO Anpatient 2 - ER/Outpatient 3 - DOA ng Home 5 Residence 8 D Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 CNatural 1 YES 2 NO Investigation Accident 28e. PLACE OF INJURY — All home, farm, street, factory, office building, atc. (Specify) 3 🗌 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Nomicide determined 29e. CERTIFIER 1 SCERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner ea stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(s) and manner ea stated 296. SIGNATURE AND TUTLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JASLUE LL AVE AIR

32 REGISTRAR'S SIGNATUR whi Studion Revol

BALTIMORE, MARYLAND 21215-0020	urs after death. Page 6 may be retained by the hospital or attending physician.	in by the funeral director, page 5 should be detached for use as the burlai-transit perm
		filled
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit perm

3	1. DECEDENT'S NAME (First, Middle,	Lest) .	CERTIFIC			2. DATE OF DEATH		3. TIME OF DEATH	
	Naomi	Virginia H	Kendle			Februar	DAY	YEAR 995	
	4. SOCIAL SECURITY NUMBER 215-18-1380	1 □ M 2 ☐ F		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) Sept 6 1	6	BIRTHPLACE (State or Forely Country) Maryland	
OR	98. FACILITY NAME (If not institution, Fahrney-Keedy	Home	9	Boons	or Location of DE	ATH		y of DEATH	
DIRECTOR		ounty ashington		TOWN OR LOCAT			10d. INSIDE CITY LIMITS? 1 YES 2X NO		
RAL	100. STREET AND NUMBER 2646 Beaver Cr		T T S		f. ZIP CODE		EN OF WHAT COUNTRY?		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I	2 XNO	If yes, sp	21740 CENDENT OF HISPAN Decity Cuben, Maxices S 2 M NO Specify	n, Puarto Rican, etc.)	Specify:		
LETED	15. DECEDENT'S (Specify only highest	t grade completed)	18a. DECEDENT'S US (Give kind of wor life. Do NOT use	rk done during mo	ON ost of working	16b. KIND OF	BUSINESS/INDUS	White	
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)		maker		н	er own	home	
CO =	17. FATHER'S NAME (First, Middle, Last David W. Hous				100	ME <i>(First, Middle, Meid</i> tta Troxe			
TO BE	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural F	loute Number, City or	Town, State, Zip Co		
	Leon Miller		P.O. BO		Funkstov			734 ty or Town, State	
	21. SIGNATURE OF FUNERAL SERVI	CE LICENSEE	melery cromatory or other est Haven	22. NAME AI 415 E	ND ADDRESS OF FAC	Minni Blvd. Ha	ch Fune	eral Home wn, Md. 2174	
CERTIFICATION	23. PART I. Enter the diseases shock, or heart fel IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if sny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initieted events resulting in death) LAST	b. Due to (or as de de de de de de de de de de de de de	d the deeth. Do not beech line. A CONSEQUENCE OF: A CONSEQUENCE OF: A CONSEQUENCE OF:	22. NAME AI	NO ADDRESS OF FACE Wilson ode of dying, auch	Minni Blvd. Ha	ch Fune	eral Home wn, Md. 2174 st, Approximate interval Bettonset and E	
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First,											3. TIME OF DEATH			
				in KLINE								Feb.		1995	YEAR	815 Rest 11
		4. SOCIAL SECURITY NUMB	ER	5. SEX		In yrs. last birthd	MOI	UNDER 1 YE	-	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year) May 8 1905			S. BIRTA Counti	NPLACE (State or Foreign
Plo		214-09-3698	ofe of a state of	1 X M 2 F	89	YR							8 190		M	laryland
3 should	œ	9a. FACILITY NAME (If not in: 13822 North					96	a. CITY, TO								
1, 2,	DIRECTOR	RESIDENCE OF DEC		y Drive					ная	gers	town	1	Washington			ton
sades	RE	10a. STATE	10b. COUNT			10c.	CITY, TO	OWN OR LO	OCATI	ON			10d, INSIDE CITY LIMITS?			10d. INSIDE CITY
H. F.		Maryland 100. STREET AND NUMBER	Was	hington			На	igers		_						1 TES 2 NO
sit per	RA	13822 North	V2110	y Drivo					101.	ZIP CODI	E 1742					WHAT COUNTRY?
physician. burial-transit permit. Pages 1, 2,	FUNERAL	11. MARITAL STATUS	valle	12. WAS DECEDEN				13, WAS	DECE			NIC ORIGIN? (Specify Yes or No. 14. I			S.A.	E — American Indian,
as the buri	B⊀	1 Never Married 2 3 X Widowed 4 Divo		FORCES? 1		YES 2 NO If yes, specify Cuban, Maxican,					n. Puerto Ric	n. Puerto Rican, etc.) Black,			k, White, etc.	
S at	9		EDENT'S EDU			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					16b, I	(IND OF BUS	SINESS/INI	DUSTRY	WILLES	
he hospital or atti detached for use once.	COMPLET	Elementary/Secondary (0-		College (1-4 or 5	-)	life. Do NOT use retired.)					Manufacturer					
the hosp detached		8 17. FATNER'S NAME (First, MI		Parts Expeditor								1				
by the	Ü U	Charles Kline						18. MOTNER'S NAME (First, Middle, Meiden Surname) Lizzie Barkdoll						126		
should be notified at	0	19a. INFORMANT'S NAME (7)		19b, MAIL	NG ADI	DRESS (Str	eet an			Poute Number		n, State, Zip	Code)			
y be ret age 5 s	2	Ronald Kli	ine			1382	2 N	orth	Va	alle	y Dr	ive	Hager	stow	n, M	aryland 2174
e 6 may ector, pa must b		20a METHDD OF DISPOSITION 1 ABurial 2 Cremation	n 3 🗆 Rem	oval from State	20b.	PLACE AND DA	TE OF DI	ISPOSITION	N /Narr	ne of		DATE		CATION —		
direct direct		1 LaBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 3-1-95 Hagerstown, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home														
hours after death. Page 6 may be retained by the hospital or ed in by the funeral director, page 5 should be detached for u or removal. medical examiner must be notified at once.		Scot	41)	71	ne	ul		1				FIL				Home Md. 21740
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or remove IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical	CERTIFICATION	shock, or heart feilure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF):										Onset and Death				
attendin rital Hyg	CERT	resulting in death) LAST														
uires that the isigned by the Health and Me Dws any inju	MEDICAL	PERFORMED? 1 YES 2 ND AMALABLE PRIOR COMPLETION OF OF DEATH?											WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND			
s beer of sp. of	N.	DID TOBACCO US	SE CONT	RIBUTE TO CA	USE OF	DEATH	YES [□ NO		UNC	ERTAIN	V.D.				
N: The ficate has State D state D	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	MEDICAL	HOSPITAL:		6. PLACE DF D	ОТ	THER:								
Certification of or	ž	27. MANNER-OF DEATH		28a. DATE OF	INJURY	28b.	IME DE	26c.	INJU	RY AT	sidence	6 Other (Specify)	NJURY OC	CURED	
G PH er this sth will	BYF		ending restigation	(Month, D	ay, rear)		NJURY		WOR YE	K7	NO					
ATTENDIN CTOR: Aft s after dez	ETED E	3 Suicide a 🗆 C	Could not be setermined	28e. PLACE O building,	F INJURY - etc. (Specif	At home, fare	n, atreet	t, factory, c	office			28f. LOCAT City or	ION (Street a Town, State)	nd Number	or Rural R	Route Number,
PITAL OR IERAL DIRI In 72 houn	COMPLE			CIAN: To the best of) and manner as stated,
THE HOS THE FUN Flied with	HH H		Sty N.	1 pre							NSE NUM	-		29d, DAT	E SIGNED	Month Cay, Year)
E E & E	2	30. NAME AND ADDRESS DE	PERSON WH	COMPLETED CAUS	78	TN (ITEM 27)	pe, Print		0/	2018	10%	17	PA Ve	tus	100	4/ 2/21
		FEB 2 8 1995	Jala	132. REGISTRA	BY SIGNA	TURE	,				/	1	1		1	11. 1. 14

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

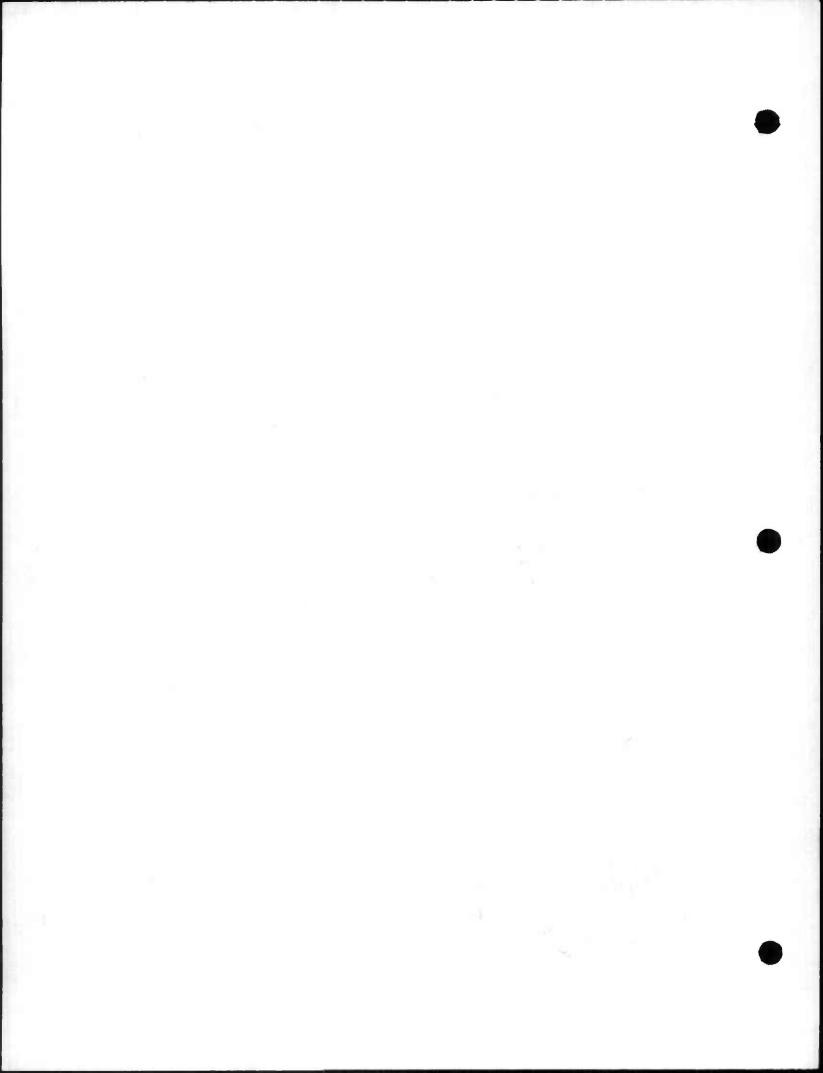
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

	TIEGIOTI IAT			ERTH	CAL		DEA	П		REG. NO.				
9	1. DECEDENT'S NAME (First, Middle, Last) Louis		Kne	cht					2. DATE OF MONTH	0/		195	3. TIME OF O	90%
	4. SOCIAL SECURITY NUMBER 209-03-1889	5. SEX 1XXX 2 F	6. AGE (In yrs. las	st birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, Sept	BIOTH	1917	e. BIRTH	PLACE (State of	Korwan
	9a. FACILITY NAME (If not institution, give str	eet and number)		9b. CITY, TOWN OR LOCATION								INTY OF DE		
E	Washington Cou		spital											
DIRECTOR	RESIDENCE OF DECEDENT		oprodr	al Hagerstown					Washing				30011	
Ä	10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION							10d. INSIDE C	ITY		
5	Maryland Washi	Ington		Hagerstown									LIMITS?	□ NO
AL	10e. STREET AND NUMBER						10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			_
FUNERAL	502 Lindhaven I	or. Apt	. C			2	2174	2			Ħ.	U.S.A.		
5	11. MARITAL STATUS	T EVER IN U.S. AF	IMED	13.	WAS DEC	ENDENT O	F HISPAN	IC ORIGIN?	Specify Yes		14. RACE	— American Ir	ndlen.	
BYF	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 1	2 NO I If yes, specify Cuban, Mexican					en, Puerto Rican, atc.) Black, White, atc.					
COMPLETED	15. DECEDENT'S EDUC	16a. DE	CEDENT'S	USUAL O	CCUPATIO	N		16b, K	ND OF BUS	INESS/INC	DUSTRY	WIII		
ᄪ	(Specify only highest grade of Elementary/Secondary (0-12)	. Iffe	ive kind of v Do NOT us	e retired.)			g							
릴	8	Se	Security Guard					Se	curi	ty				
ő	17. FATHER'S NAME (First, Middle, Last)	WALL CLICK	18. MOTHER'S NA					ME (First, Mid	die, Maiden	Sumame)				
BEC	Thomas	KNECHT				Ma	ry			M	UTTE	ER		
10 B	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street ar	nd Number	or Rural R	loute Number,	City or Town	, Statu, Zip	Code)		
F	Pauline Knecht		50	02 L	indh	nave	n D	r. /	Apt. (Hac	rers	town	Md.2	17/12
	20a. METHOD OF DISPOSITION 1 1 Burial 2 Cremation 3 Remove	and from State	20b. PLACE	ANDDATE	F DISPOS	ITION (Na	ne of		DATE	20c. LO	ATION -	City or Tov	rn, Stata	1/4/
	4 Donation 5 Other (Specify)		Grand	lvie	ner place) W C∈	emet	erv		2 27	Joh	nst	Own	Pa	
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE			22.	NAME AN	D ADDRES	S OF FAC	e Sei			,		
	Lined C B	Warren									_	1	(.) O.1	7/0
	23. PART I. Enter the diseases, or co	omplications that	coused the de	eth. Do n	ot enter	the mod	ie of dyl	na. such	L • Dò	gers	atory an	II, I	Id. 21	
	anock, or neert failure. L	ist only one cau	se on each line										interval	Between
- 1	immediate cause (Final disease or condition - Chronic Obstructive Pulmonary disease existing in death) - Chronic Obstructive Pulmonary disease									Onset's	nd Death			
1	resulting in death) - a Due to (or as a consequence of):										5			
z		Preu	mon	ia									11 4	ech
CERTIFICATION	Sequentially list conditions, if any, lesding to immediate		OR AS A CONSEC):		1		_	1			•	
S	CAUSE (Disease or Injury	Conge	25tiv	e	H_1	Par	+	1	-ai	lur	e			
=	that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF): - (
H	resulting in deeth) LAST													
- 11	PART II. Other aignificant conditions	contributing to	death but not r	esulting i	n the un	derlying	COURA	lven in F	Part i 2	- WECAN	ALITOROV DAL MERE ALITY			Favores
EDICAL				out not resulting in the underlying ceuse give				use given in Part i. 24s. WAS AN AUT PERFORME						
											NO		OF DEATH?	CAUSE
Σ	DID TOBACCO USE CONTR	IRLITE TO CAL	IICE OF DE A	TU VE	c 🗆 .	10 [LINIO	CDTA IN					1 YES 2	NO
AN	25. WAS CASE REFERRED TO MEDICAL	IDOIL TO CA		E OF DEAT			UNC	ERTAIN						
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER	1:								
ξ	27. MANNER OF DEATH	28a. DATE OF		28b. TIME	- T	28c. INJU		-	26d, DESCR	-	Illey oc	CURED		
	1 Natural 5 Pending	(Month, Da		INJ		WOF	HC?		200. DESCH	IBC HOW IN	JUNY OC	COMED		
ВУ	2 Accident Investigation 3 Suicide & Could not be	26a. PLACE OF	INJURY — A1 ho	me, farm, s	treet, facto			-	261. LOCATI	ON (Street as	od Number	or Rumi Bo	urta Mumbar	
COMPLETED	4 Homicide 8 Could not be determined	building,	ntc. (Specify)			,			City or	own, State)	io ivamber	OF FIGURE PRO	ute reumber,	
91	29a. CERTIFIER 1 CERTIFYING PHYSIC	AN. To the heat of	- les des de										-	
29a. CENTIFIEN 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and pi one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death or														
8				i, iii iiiy o	pittion, de	ann occure	o at the 1	ime, data an	piace, and	dua 10 th	e cause(a)	and manner as	stated.	
BE	296. RIGHATORE AND STILE OF CERTIFIER	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)								(1)				
o Maken Jarman MU							リニ	3 5	71		F	eb.	24,1	145
	30. NAME AND ADDRESS OF PERSON WHO	CONFLETED CAUS						20. 4	3		4.1			1/
- 1	IN STOCKER IN	DOWN I	IIIO O	redic	a	CON	MALIS	UA	10'	7W	L	A 16 1	1) ()	7/10
	31 DATE EU ED (Mars)	200000		LGV II	31. DATE FILED (Month, Day, Year) 39. REGISTRAY'S IGNATURE									
	31. DATE FILED (Month, Day, Year) FFB 2: 7 1995	30. RECHOTRAL		T CONT		<u> </u>	7	NU	, ,0	-	Ha	g Mc	0.01	140



pluor	
JAN: The law requires that the death certificate be executed within Z rifficate has been signed by the attending physician and completely if the State Oept, of Health and Mental Hyglene prior to burial, cremation	ADORTANT if item 22 is marked or item 23 shows any injury or other fraumatic avantage must be modified at any

	MANKA KOCIUBINSKA							70	0/8/	5	
	FOR 1 - STATE REGISTRAR	STATE OF MARY		TMENT OF H			YGIENI EG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3. TIME OF DE	ATH	
	MANKA WA	ANDA	KOCIUBI	INSKA		Feb.	21	1995	4:00	Ам	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E	BIRTH		8. BIRTHPLACE (State or		
	437-44-4112	1 🗌 M 2 🙀 F	88 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Da		1907	Ukraine		
	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN C	OR LOCATION OF D		y 10,		TY OF DEATH		
5	SALTSBURY NURSING	& REHAR CEN	TTER	SALTSB	BURY, MD.		WICOMICO				
ठ	SALISBURY NURSING	a Raine on				·		VICO	100		
DIRECTOR	10a. STATE 10b. COUNTY			TOWN OR LOCAT					10d, INSIDE CIT LIMITS?	ſΥ	
	Maryland Wico	mico		Salisbur			1 X YES 2				
FUNERAL	A .			101	ZIP CODE			EN OF WHAT COUNTRY?			
岁	612 Pine Bluff Rd				21801			US			
	1 X Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuban, Maxica	en, Puerto Ricar	pecify Yes i, etc.)	or No — 1	 RACE — American Inc Black, Whife, etc. 	flan,	
B√	3 Widowed 4 Divorced	IF YES, GIVE WAR OR I	DATES	1 TYES	2 K NO Specif	fy:			Specify: White		
	15. DECEDENT'S EDUCA		16a. DECEDENT'S I	USUAL OCCUPATION	ON	16b. KIN	D OF BUS	INESS/INDU		_	
Li	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)	st of working						
N P	11	4	Register	ed Nurs	е	Hea	1th	Care			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle	e, Maiden S	Sumame)			
BE	Dimitri	Kociubins	ka		Paulir	ne J.	(u	nknow	n)		
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural						
	Pat H. Cavanaugh								MD 21826		
	20a. METHOD OF DISPOSITION 12 Buriel 2 Cremefion 3 Remov	ral from State ce	b. PLACE AND DATE O metery, crematory or oth	her place)	DATE			ty or Town, Stata			
	4 Donetion 5 Other (Specify)		Wicomico Me		rk ID ADDRESS OF FA	2/25	Sa:	lisbu	ry, MD		
	1/11/0/1	11.	γ		oway Fur		ome				
	1016/du	wy		501	Snow Hil	1 Rd.,	Sa1	isbur	y, MD 2180	1	
	23. PART i. Enter the diseases, or co ehock, or heart failure. Li	mplications that fause ist only one ceuse on a	the death. Do no	ot entar the mo	da of dying, suc	ch es cardiac	or reepir	atory arre	et, Approxir		
	ehock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Out 10 (on as a consequence or):									nd Death	
	resulting in death)	Reffer	Mrs.	ache	du	1	2		1 de	5	
		DUE TO (OR AS	A CONSEQUENCY OF			8			/	/	
O N	Sequentially list conditions,	1000	A CONSEQUENCE OF	ne	neni	4			400	-	
¥	if any, leading to immediate cause. Enter UNDERLYING	District Cons.							r		
Ĕ	CAUSE (Diseese or injury that initiated evante	DUE TO (OR AS	A CONSEQUENCE OF	i							
ERTIFICATION	resulting in death) LAST								1		
O	PART ii. Other aignificant conditions	contributing to deeth	but not resulting in	the underlying	cause olven in	Part i lass	. WAS AN /	HITOBEY	24b. WERE AUTOPSY	PHIPHUO.	
MEDICAL	Xlason m	7		, the analyting	g codes given in	7 41().	PERFORI		AMILABLE PRIOR	A TO	
ED	11.67	-1/-/-	1 /20			18	YES 2	NO	OF DEATH?		
Σ	DID TOBACCO USE CONTRI	BRITE TO CAUSE O	DE DEATH VE	S D NO D	UNCERTAI	N C			1 [] YES 2 [NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	BOIL TO CAUSE C	28. PLACE DF DEATH		ONCERIAI						
Sic		HOSPITAL: 1 Inpatient 2 ER/Out		OTHER	e 5 🗌 Rasidenca	A Chhar (So	pol(v)				
H	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	28d. DESCRIE		JURY OCCU	IRED		
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	INJU		RK? YES 2 NO						
	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJUR building, etc. (Spe	Y — At home, ferm, at	reat, fectory, office		28f. LOCATIO	N (Street ar	nd Number o	r Rural Route Number,	$\overline{}$	
TED	4 Homicide determined					Only or 10	WII, SIERO)			- 1	
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICI	AN: To the best of my know	viedge, dasth occurred	d at the time, date	and place, and due	to the cause(s	and mann	ner as stated	1.		
ŏ	One) 2 MEDICAL EXAMINER:									stated.	
	296. SIGNATURE AND JITLE OF CENTRED				29c. LICENSE NU	MBER		29d. DATE	SIGNED (Month, Day, Year)	
) BE	0// X	rec			D-293	349		12/	22/36	`	
유	30. NAME AND ADDRESS OF PERSON WHO							1	1		
	WILLIAM ROBINS, M.D	. 1104 HEAL	THWAY DRI	VE, SALI	SBURY, M	iD.					
	31. DATE FILED (Month, Day, Year) FEB 2 7 1995	32. REGISTRAR'S SIGN	VATURE								
	/ ED 2 / 1995	Have a way	Arthorna, war							- 1	

ital or attending physician. BALTIMORE, MARYLAND 21215-0020

for use as the burial-transit permit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the filled within 70 hours after death with the State Dear of Health and Marial Housians print to bring in remarking or removed.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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								95	07876	
FOR STATE REGISTRAR	STATE OF	MARYLAND /	DEPART ERTIFIC	MENT (OF HEA	LTH AND	MENTAL HYGIEN	E		
1. DECEDENT'S NAME (First, Mic	idle, Last)			. 1			2. DATE OF DEATH		3. TIME OF DEATH	
	MABEL DARI	34		KN	16H	T	MONTH DA		95 1832	P
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	F UNDER 1 1	EAR IF	UNDER 24 HRS.	7. DATE OF BIRTH	_	BIRTHPLACE (State or Foreign	lan
220-66-4362	1 🗌 M 2 🕸	84	YRS.	ONTHS	MYS HO	URS MIN.	(Month, Day, Year) July 15,19	10	Virginia	
	PENINSULA REGIONAL MEDICAL CENTER						EATH		Y OF DEATH	
RESIDENCE OF DECE										
	b. COUNTY		18c. CITY,	TOWN OR	LOCATION				10d. INSIDE CITY	151
Virginia	Accomack Co		At	lanti	ic, V	'A			LIMITS? NES 2 NO	0
10e. STREET AND NUMBER					10f. ZIP	CODE		10g. CITIZEI	N OF WHAT COUNTRY?	
10133 Atlan	tic Rd.				2	3303		USA		
11. MARITAL STATUS		ENT EVER IN U.S. AF	MED	13. WA	S DECENDE	ENT OF HISPAI	NIC ORIGIN? (Specify Yea	or No- 14	. RACE — American Indian,	
1 Never Married 2 Mer 3 Wildowed 4 Divorced	IE VES CIVE	1 YES 23 WAR OR DATES	NO			Cuban, Maxica NO Specif	nn, Puerto Rican, etc.) y:		Specify: White	
15. DECEDE (Specify only hig	NT'S EDUCATION thest grade completed)	16a. DE	CEDENT'S US	WAL OCCI	JPATION	working	166, KIND OF BUS	INESS/INDUS	TRY	
Elementary/Secondary (0-12)	College (1-4 or	5 +) life	. Do NOT use	retired.)						
12		C	wner/	Manag	<i>jer</i>		Dry Cle	aning		
17. FATHER'S NAME (First, Middle	, Lest)				18.	MOTHER'S NA	ME (First, Middle, Maiden	Sumame)		\neg
John T. Dar	by					Berti	e Thornton			
19a. INFORMANT'S NAME (Type/	Print)	19	b. MAILING A	DDRESS (S	treet and No	umber or Rural	Route Number, City or Town	, State, Zip Co	ode)	
Jack Darby	- Nephew		9207	Lank	ford	Hwy.	Temperance	ville,	VA 23442	
20a. METHOD OF DISPOSITION 1 Cremetton	3 Removal from State		AND DATE OF		ON (Neme of	1	DATE 20c. LOC	ATION — CIT	y or Town, State	
4 Donellon 8 Other (Spe	icify) _		ing's		tery		2-18-95	Dak Ha	111, VA	
21. SIGHATORE OF PUBLICAL SE	PRVICE LICENSES	1				DDRESS OF FA	CILITY			
Hospin	140/1/2	2.16 1					eral Home			
23. PART I. Enter the disea	sea, or complications th	ot raused the	eth Do not	J 50)1 Sn	ow Hil	1 Rd., Sa1	isbury	, MD 21801	
ahock, or heart	fallure. List only one or	use on each line	t.	enter tr	e mode o	n ayınığ, suc	n aa cardiac or respii	atory arrest	t, Approximeta	
MEDIATE CAUSE (Final	E10-00-00-00-00-00-00-00-00-00-00-00-00-0	61,					_		Onset and D	eath
disease or condition resulting in death)	a. 6	tchete	MU	0/11	col.	P 7	Afacto		MINUT	5
	DUE	O OR AS A CONSE	QUENCE OF):				c jesc je	-		3
Sequentially list conditions	б									
If any, leading to immediate	DOE 1	O (OR AS A CONSE	DUENCE OF):							
cause. Enter UNDERLYING CAUSE (Disease or Injury	2 a									- 1
that initiated eventa	DUE T	O (OR AS A CONSE	DUENCE OF):							
resulting in death) LAST	d									
2424										
PART II. Other significent	conditions contributing t	o deeth but not r	esulting in	the unde	rlying cau	use given in	Part I. 24a, WAS AN /	MTOPSY	24b. WERE AUTOPSY FINDS WAILABLE PRIOR TO	
							1 YES 2		COMPLETION OF CAUS OF DEATH?	
									i or ordilli	

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

26. PLACE OF DEATH (Check only one)

25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1 © Inpetient 2 □ ER/Outpetient OTHER: 1 - YES 2 NO 3 DOA ng Home 5 - Residence 8 - Other (Specify)

26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 1 Natural
2 Accident

3 Suicide 4 Homicide

29a. CERTIFIER

8 Could not be

26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

26b. TIME OF

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

1 YES 2 NO

28c. INJURY AT WORK?

HIGHATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMI
RAI X	24:2

30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

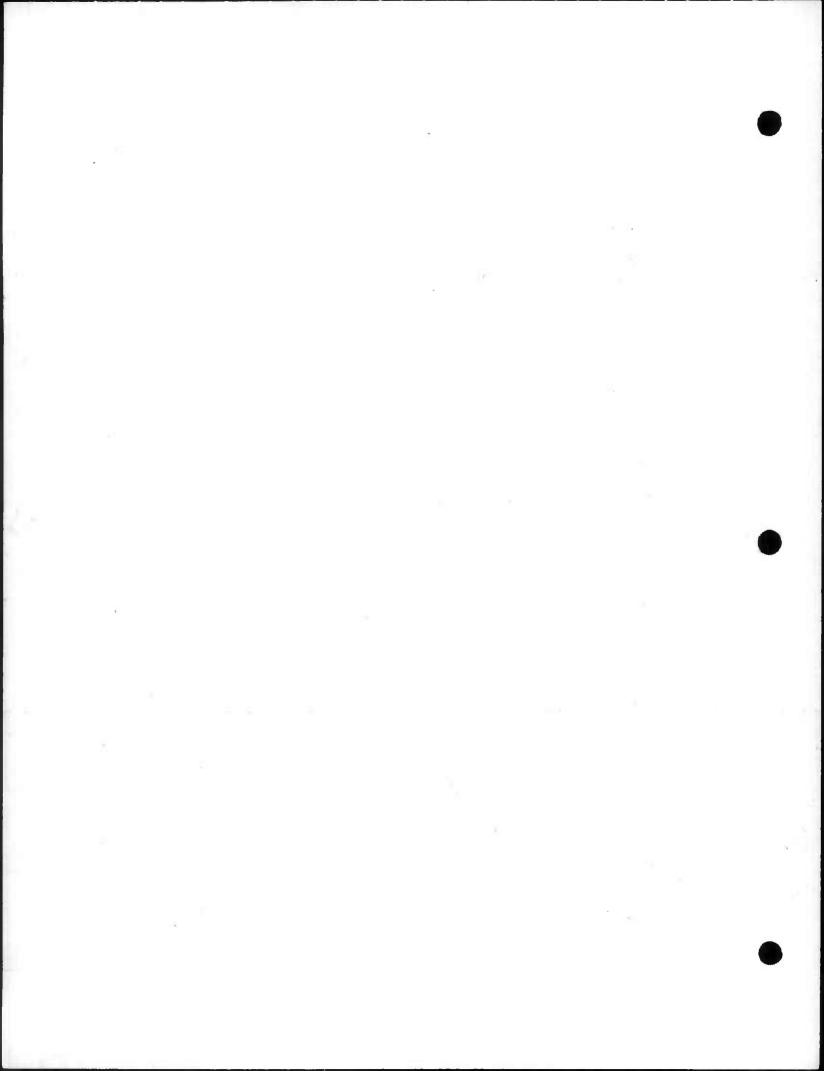
JEFREY W
31. DATE FILED (Magnity, Day, Year)
FEB 21 1995 elANd 32 AEGISTBAR'S SIGNATURE 34768

29d. DATE SIGNED (Month, Day, Year)

28d. DESCRIBE HOW INJURY OCCURED

DHMH-16 Rev 1/89

1 - YES 2 - NO



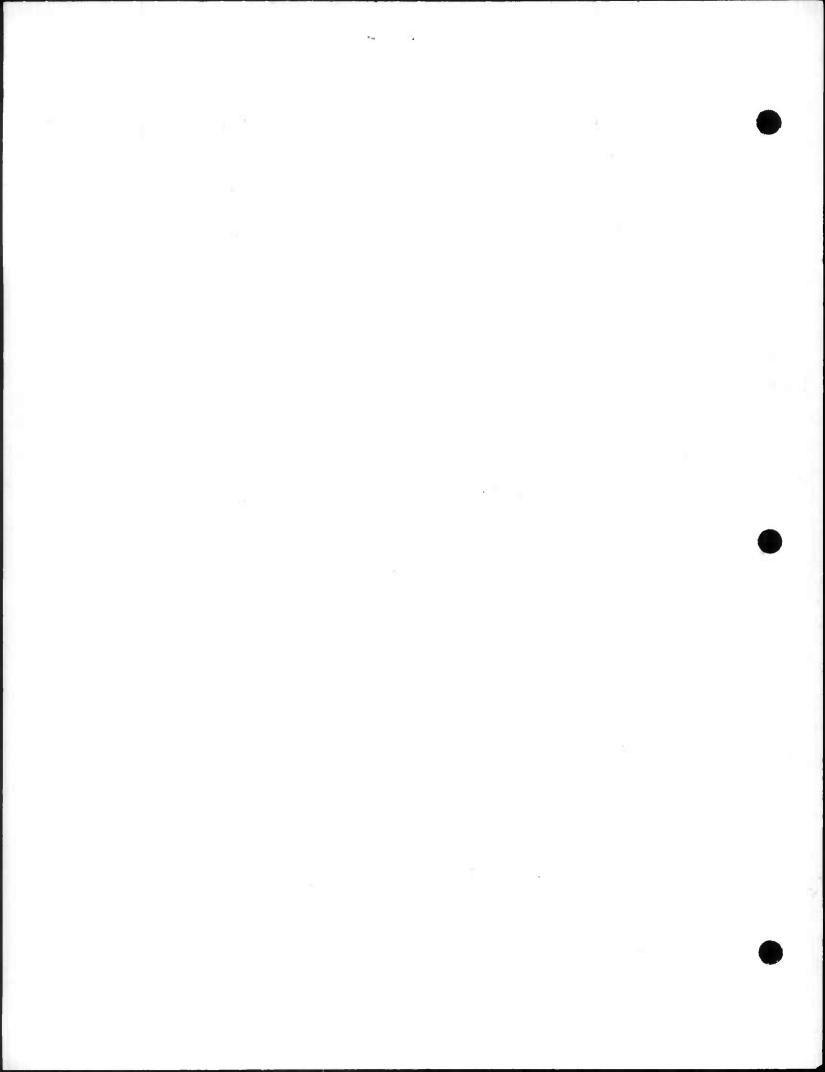
			1 - STATE REGISTRAR	STATE OF MAR				MENTAL HYGIEN			
REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH 3. TIME OF DEATH				
	-		Ethel Geor	ge Kerr				February **		5 8	3:25P M
			4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthd		IF UNDER 24 HRS.	7. DATE OF BIFTIN	0.1	BIRTHPLA	CE (State or Foreign
P	Ì		114-09-5216	1 □ M 2√√F	79 YR	3. MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 03-07-191		country) ew Ha	empshire
shout			9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY		
2, 3		5 8	22 Beacon Court			Anna	apolis		Anne	Arur	nde I
les 1,		DIRECTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	10c.	CITY, TOWN OR LOC	ATION			104	I. INSIDE CITY
permit. Pages 1, 2, 3 should	-	PHO	MD Anne	Arundel		Annai	oolis				LIMITS? YES 2 NO
Fe		AL	10e. STREET AND NUMBER				01. ZIP CODE		10g. CITIZEN		
-55		FUNER	22 Beacon Court				21403		Unite	ed St	tates
020 physician. burial-transit		2	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVE FORCES? 1 Y	ER IN U.S. ARMED	13, WAS DI	ECENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No- 14.	RACE - /	American Indian, nite, atc.
-00-		BY	Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES	1 🗆 YE	S 2X NO Specif			Specific	nite
21215-0020 If or attending physic for use as the burial		B	15. DECEDENT'S EDI	JCATION	16a. DECEDEN	T'S USUAL OCCUPAT	TION	16b. KIND OF BUS	SINESS/INDUST		1110
212 al or a for us	. 1		(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind life. Do NO	of work done during r T use retired.)	nost of working				
AND 2121 the hospital or att	ej .	COMPLET		1	Ham	emaker		Hom	е		
LA!	t once.	BE CO	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden			
MARYLAND 21215-0020 retained by the hospital or attending physician, 5 should be defached for use as the burial-tran	ed at		Thomas George 190. INFORMANT'S NAME (Type/Print)					lie Zapate			
	notified	2	Thomas W. Kerr		1			Route Number, City or Town			
ORE, 6 may be ctor, page	9		20e. METHOD OF DISPOSITION			Grisdale TEOFDISPOSITION		iva, Maryl	CATION — City		Sinte
MOR	must		Donetion 6 ☐ Other (Specify)	noval from State	cametery_exematory	or other place)	atory 3/3		ntwood.		
TIM Page	iner		M. SHENATURE OF FUNERAL SERVICE LI	CENTEE	1/	22. NAME	AND ADDRESS OF FA	outsohn M.	Taylor	Fune	eral Home
BALTIM or death. Page the funeral dive	examiner		totalal a	1 4.1	n	147 [Duke of G	loucester S	St. Anr	napol	lis, MD
B A A	medical		23. PART I. Enter the diseases, or	complications that cou	sed the death. D						Approximata
			shock, or haart failure.	List only one cause o	n aach ilna.					i	interval Between Onset and Death
() ()	rent, the		disease or condition and CASTRIC CARCINOMA ZVI						ZYRS		
	5			OUE TO (OR A	AS A CONSEQUENCE	OF):					
68 and c	or other traumatic or	O	Sequantially list conditions,	b. OUE TO (OR A	AS A CONSEQUENCE	OE)					
0 3 83	Tage .	ERTIFICATION	cause. Enter UNDERLYING								
Certificate	the	Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF):							
eath certi		E	resulting in daath) LAST								
RDS, at the de by the a	shows any injury,	C	PART ii. Other eignificant condition	ne contributing to deat	h but not recultir	ng in the underlyi	ng ceuse given in	Part i. 24s. WAS AN	AUTOPSY	24b. WEF	RE AUTOPSY FINDINGS
ORIC that the ed by	any i	ICAL	DEEP VE	IN THRE	WSOS	S		PERFOR	9 4	AWAR	LABLE PRIOR TO
RECO requires the	0W\$	MEDI						_ ' ' ' ' ' ' '	2,00		DEATH? YES 2 NO
C 5 8	23 sh	ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	YES NO [UNCERTAIL	N 🗆			
F F 2 2	item 2	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D	EATH (Check only one OTHER:)				
F VIT.	0 1	IXSI	1 TYES 2 NO	1 Inpatient 2 I ER/C		4 - Nursing No		6 Other (Specify)			
O F SE	- 34		27. MANNER OF DEATH Netural 5 Pending	(Month, Day, Yes		INJURY W	JURY AT	28d. DEŞCRIBE NOW II	NJURY OCCURE	iD.	
	is ma	B	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJI	JRY At home, fam	m, street, factory, off	YES 2 NO	281. LOCATION (Street e	and Number or B	turni Brusha	Membar
OIVISION OR ATTENDING DIRECTOR: After	28		4 Homicide 6 Could not be determined	building, etc. (S	Specify)	, ,		City or Town, Stete)	THE THEIR OF THE	DIET FIDO(E)	rvurnuer,
OR /	item item	COMPLET	29e. CERTIFIER (Check only	ICIAN: To the best of my ki	nowledge, death occ	urred at the time, dat	a and place, and due	In the cause/e) and man	mar na stated		
HOSPITAL FUNERAL	# H	NO N		On the baels of examina						use(s) end	menner ee stated,
E FUNEF	IMPORTANT: II	Ö	29b. SIGNATURE AND TITLE OF CERTIFIE		^		29c. LICENSE NUI		29d. DATE SIO		
E C C C C C C C C C C C C C C C C C C C	N O		Resemble	NOR W	NP		D1636	64	121	28/	95
		2	30. NAME AND ADORESS OF PERSON WE							31	10
			Peter Graze, M.D			d Annapol	is, MD 2	1401 (410-5	573-530)0)	
			31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S		11					
	L		MAR 02 19	JJ July Oa	veleor Randi	LEG.					_

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 40 2. DATE OF DEATH + Course Mar Garet IRENE 1995 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTS IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig DAYS HOURS 1 M 2 K F 87 YRS. 220-54-5605 Jan. 12, 1908 Maryland permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not inetitution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harford Memorial Hospital Havre de Grace Harford 10e. STATE 10h COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Joppa 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the burial-transit 1414 Philadelphia Road 21085 USA noun after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced white 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homemaker Home notified at once, 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edward Granville Hoover Mary Stephenson Guy BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Karl K./ Keithley 1414 Philadelphia Road, Joppa, Maryland 21085 ä 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State most and completely filled in by the funeral director, I burial, cremation, or removal. Cremetion 3 cametery, crematory or other place)
Trinity Lutheran Ch. Cem. 5. Other (Specify) 3/3/95 Joppa, Maryland examiner 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. medical 23. PART I, Enter the disease es or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List pnly one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death 휥 disease or condition Connany certery durane years resulting in death) event. traumatic CERTIFICATION Sequentially list conditions, prior to t DUE TO JOB AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury affending physician other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST the affert Injury, conditions dontributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS signed by 1 Health and 0 amy MWAILABLE PRIOR TO COMPLETION OF CAUSE shows No TI YES 21 has been Dept. of) DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one certificate to 1 YES 2 NO sellent 2 - ESVOutpetient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) the state of b 27. MANNER OF DEATH 28s. DATE OF INJURY this c with a 28c. INJURY AT WORK? is marked, Netural 1 YES 2 NO BY deuth Ather Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Discide 281. LOCATION (Street and Number or Rural Route Number City or Yours, State) COMPLETED # Could not be DIRECTOR 崔 4 📋 Homicide 23 HOURS 8 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end manner as stated. FUNERAL WITHIN 72 II HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 29c LICENSE NUMBER 296. SHOWN UNE AND JUTLE OF CENTERS BE 29d. DATE SIGNED (Month, Day, Year) 28 339 5 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRAILICH

Jaha Davelson Randall

31. DATE FILED (Month, Day, Year)



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after dea	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical axa
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	80	DIRE	DOUR	tem
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95 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Feb. 24, Rosa V. Kendall 1995 9:20 p M 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign 1 M 2 X F 218-36-9096 85 Oct. 22, 1909 Maryland 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Wilson Health Care Center Gaithersburg Montgomery 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Gaithersburg 1 X YES 2 NO 10e, STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 211 Russell Avenue 20877 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married il yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 XNO Specify: В Specify: 3 Widowed 4 Divorced White COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only h Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Lawyer Maryland State Government 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surneme F Ralph E. Kendall BE Florence Crouch notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gerald L. Gimmel Professional Drive #145, Gaithersburg, MD 20879 must be 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 Donation 5 Other (Specify) Metropolitan Crematory 2/26/95 Alexandria, VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive 0. Gaithersburg, MD 20877 item 23 shows any injury, or other traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not snier the mode of dying, such as cardiac or reapiratory arrest, shock, or heert feiture. Liet Dniy Dne ceuse Dn eech line. Approximate interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition_ DUE TO (OR AS A GONSEOUENCE OF) Im balanca resulting in death) Chal tailure
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other eignificent conditions contributing to death but not recuiting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 MO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 VES 2 1 Inpetient 2 ER/Outpetient 3 DOA 6 Other (Specify) 10 DIRECTOR: After this cer hours after death with the item 28 is marked, o 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural м 1 YES 2 NO BY 2 Coldent 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the beale of examin stion and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 1995 9

Are

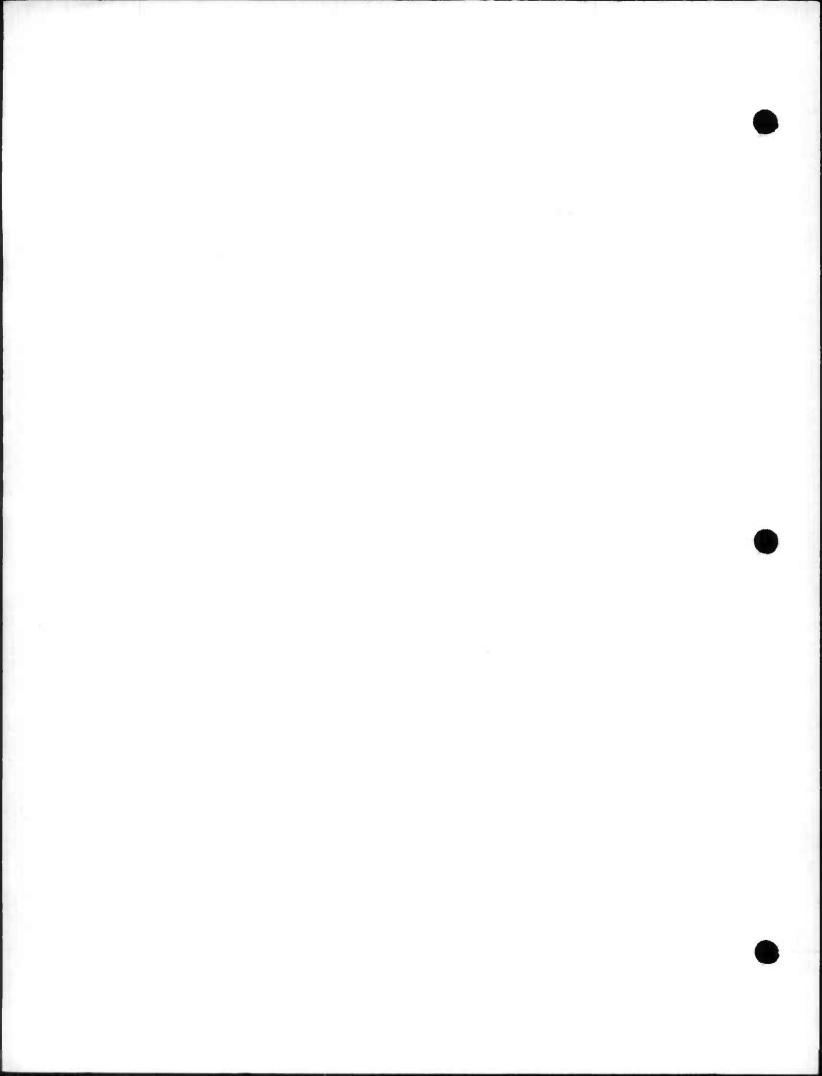
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 207 Brooke

Davidson Randall

32, REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

02 1995



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
certificate l	ding physic Hygiene pric	r other tra
at the death	by the attent and Mental H	ny Injury, or
aw requires the	s been signed pt. of Health	3 shows a
ICIAN: The I	ertificate has the State De	or Item 2
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L OR ATTEN	L DIRECTOR:	Item 28
TO THE HOSPITA	TO THE FUNERAL be filed within 72	IMPORTANT: H

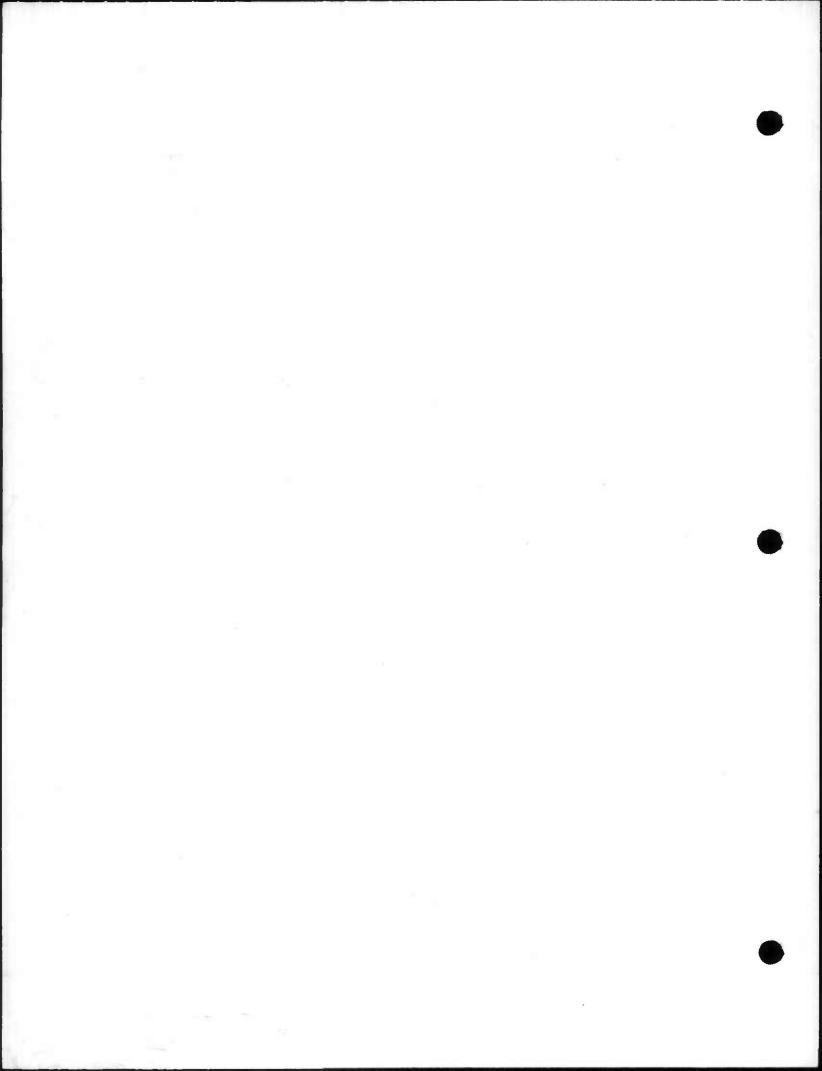
A	mended # 7, FOR 1 - STATE REGISTRAR	#166 2/28/95 STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND M	ENTAL HYGIEN		207880 County	
	1 DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER	S, SEX 6. AGE	(In yrs. leat birthday)	IF UNDER 1 YEAR		2. DATE OF DEATH MONTH 7. DATE OF BIRTH	5 10	YEAR 06 DEATH 06 SA M 8. BIRTHPLACE (State or Foreign	
	063.38.6668	1 🖾 M 2 🗆 F 78		MONTHS DAYS	MOTION MAN	(Month, Day, Year) Feb. 27, 19	95	Canada	
œ	9a. FACILITY NAME (If not institution, give so Holy Cross Hospit				OR LOCATION OF DEA	тн /9	1	INTY OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT						1101	regomery	
E	10c. CITY, TOWN OR LOCATION Maryland Montgomery Kensington 10d. INSIDE CITY LIMITS 1 10d. INSIDE CITY LIMITS 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								
	10e. STREET AND NUMBER				Of. ZIP CODE	-·		IZEN OF WHAT COUNTRY?	
FUNERAL	3612 Littledale	Road 12. WAS DECEDENT EVER II	NIIO ADMED	140 440 05	20895			J.S.A.	
B⊀	1 Never Married 2XXMarried 3 Wildowed 4 Divorced	FORCES? 1 TYES IF YES, GIVE WAR OR D	ZXXNO	If yes, s	CENDENT OF HISPANIC pecify Cuban, Maxican, S 2 ANO Specify:	ORIGIN? (Specify Ya Puarto Rican, etc.)	a or No—	14. RACE — American Indian, Black, White, atc. Specify: White	
	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of a life. Do NOT us	USUAL OCCUPAT work done during n se retired.)	ION post of working	16b. KIND OF BU	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) +5		ical Eng		Enign	eer	Engineer	
	17. FATHER'S NAME (First, Middle, Last)	la Vina			The second secon	ELLEN PA	,	9	
TO BE	Richard Will 19a. INFORMANT'S NAME (Type/Print)	is king	19b. MAILING	ADDRESS (Street	and Number or Rural Ro			p Code)	
F	Marguerita King 3612 Littledale Road Kensington, Md. 20093								
20e. METHOD OF DISPOSITION 1 Burlel 2XIX Cremetion 3 Removel from State camelery, cremetory or other place) Mt. Comfort Crematory 2/28 Alexandria, Virginia									
	21. SIGNATURE OF FUNERAL SERVICE LIC			22. NAME /	AND ADDRESS OF FACE	Joseph	Gaw1	er's Sons	
	X HOLY	recess			WI AVE NW				
	23. PART I Enter the diseases, or cahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on e	the death. Do rach line.	uova	ode of dying, auch	ea cerdlec or reap	Iratory arr	Approximate Interval Between Onset and Death	
CATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	Corel	CONSEQUENCE OF	Sala	ar Ac	ci dent	_	Turk	
CERTIFI	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	`	Polechu	7		Ture	
MEDICAL	PART II. Other algorificent condition	a contributing to death b	ut not resulting i	In the underlyle	ng ceuse given in Pa	24e. WAS AN PERFOR	RMEDI	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO CDMPLETION DF CAUSE OF DEATH?	
	DID TOBACCO USE CONTE	RIBUTE TO CAUSE O	F DEATH YE	S NO [UNCERTAIN	*	/ \	1 - YES 2 X NO	
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HØSPITAL:	26. PLACE OF DEAT	TH (Check only one OTHER:)				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MAYRER OF DISTH 1 Neturel 5 Pending Investigation 28b. TIME OF 18JURY AT WORK? M 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED								CUREO	
								Johns	
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, atc. (Spec	— At home, farm, s	street, factory, offi	ce 2	81. LOCATION (Street and City or Town, State)	and Number	r or Rural Route Number,	
COMPLET		CIAN: To the best of my know							
BE COI	296. SIGNATURE AND TITLE OF CERTIFIER		and/or investigatio	n, in my opinion,	death occured at the tin			ne ceuse(a) and menner as stated. E SIGNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATM /ITEM OT /T	Ordered	リーか	-352	P (12505	

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Bype, Print)

32. REGISTRAR'S SIGNATURE

Talia Mudlar Raylell

31. DATE FILED (Month, Day, Year)
FEB 28 1995



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			4. SOCIAL SECURITY NUMBER	PIR	5. SEX	6. AGE (In			IF UNDER	DAYS	IF UNDER 24 HRS.	7. DAT	E OF BIRT	
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	3 should	NG.	9a. FACILITY NAME (II not in Washingt			: Hos	spit	tal			ma Park			
	1, 2,	DIRECTOR	RESIDENCE OF DEC	CEDENT										
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	ij.		10s. STREET AND NUMBER	1101	- I C G O I I C L J	<u>'</u>		ST	Tve.					
	st. Se.	ERA		mptor	Drive					101	20903	₹		
0	ptysician. burial-transit permit. Pages 1,	FUNE	11. MARITAL STATUS	MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. 4BMED 13. WAS DECENDENT OF HISPANIC ORI										
MARYLAND 21215-0020	attending physics as the buri	BY	1 Never Married 2 3 Wildowed 4 Dive		FORCES?	MAR OR DAT	2 M	0	1	yes, spe	, specify Cuban, Maxican, Puarto Rican, a YES 2 M NO Specify:			
21	use as	TED		EDENT'S EDU y highest grade		1	16a. DEC	EDENT'S U	SUAL OC	CUPATIO	N st of working	16	b. KIND C	
21	ital or d for u	LET	Elementary/Secondary (0)-12)	College (1-4 or 5	+)					•		٠	
Z	the hospital detached for once.	COMPL	8th 17. FATHER'S NAME (First, M	liddle Lant)			H	ouse	WII	e 				
7	by the	CC	James S1								16. MOTHER'S NA			
AB	retained by the hospital o 5 should be detached for notified at once.	100	19a. INFORMANT'S NAME (19b.	MAILING /	DDRESS	(Street a	nd Number or Rural			
		2	William S	. Key	s (Son)							silv		
BALTIMORE,	2 2		20a. METHOD OF DISPOSIT 1 M Burial 2 Crematic 4 Donation 6 Other	n 3 🗆 Rem	oval from Stata			ND DATE OF			Part Park	/ DA		
2	. Page ral direc		21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE						D ADDRESS OF FA			
BAL	after death. Page 6 m by the funeral director, moval.		(xm	ER	: /mos	nde	u		R	OCK	DEN FUN VILLE,	MD	20	
	In the		23. PART I. Enter the d shock, or h	keasea, or e eert fallure.	complications the List only one cau	t caused t	he dea	th. Do no	t enter	the mo	de of dying, suc	h aa ca	diec or	
			IMMEDIATE CAUSE (Fir disease or condition		1	1 -					<i>c</i> .			
0	completely ial, cremati	- 7	resulting in death)	→	a. AC	OR AS A C	K	espi	rch	24	tailu	re		
BOX 68760	executed within ex- and completely fille o burial, cremation, matic event, the	_			()	ONIC	.ONSEO	Ah	tra. s	· Fi	Failu ve Lur	. ^	Die	
9 X	2 0 2	RTIFICATION	Sequentielly list condit- if any, leeding to imme-		U. See	(OR AS A C	ONSEOL	UENCE OF)	CIO	CU	ve cor	5	V 13	
80	ysiciar prior r trau	\ <u>8</u>	cause. Enter UNDERLY	ING	с.									
0	leath certificate be eatherding physician ntal Hygiene prior to y, or other traun		that initiated events resulting in death) LAS		DUE TO	(OR AS A C	ONSEOL	JENCE OF)						
RECORDS, P.O.	death c e attendi lental Hy ury, or	CER	resoning in destrij EAS		d									
DS	the d		PART II. Other significe	nt condition	a contributing to	death but	not re	sulting in	the un	jerlylng	ceuse given in	Part I.	24a. W	
OR	that the hed by the and any Ir	EDICAL	Cer	vords	ascular	F	1 cc	ide	nk				1 Y	
EC	een signed by of Health an	W		re	Kynho	ilaz	051	<u>`</u>						
	~ D ~ I	ä	DID TOBACCO U		RIBUTÉ TO CA	USE OF	DEAT	H YES	M	10 🗆	UNCERTAIL	V		
TA	SICIAN: The la certificate has the State Dep the State Dept.	CIAN	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26	. PLACE	OF DEATH	(Check o					
>	CLIAN:	IXSI	1 VES 2 NO		1 Inpatient 2		lent 3	DOA	☐ Nurs	ing Home	5 🗆 Rasidence			
ON	DING PHYS After this c death with	ву РНУ	1 Netural 5	Pending Investigation	28a. DATE OF (Month, D			26b. TIME INJU		28c. INJU WOI 1 Y	RK?	28d. DE	SCRIBE H	
DIVISION OF VITAL	TTENDI TOR: A after d	TED		Could not be determined	26a. PLACE C building,	of INJURY — ofc. (Specify,	At hom	e, ferm, str	aat, facto	ry, office			CATION (S	
D	AL OR	MPLE	one)		CIAN: To the beat of									
	HOSPITAL FUNERAL WITHIN 72	Ö			R: On the besis of a	xemination a	ind/or In	vestigation,	in my op	inion, de			and ple	
	TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE	29b. SIGNATURE AND TITLE	ghod	VVW	mys		M			D) 25	BER 82		
0			30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEAT	H (ITEM	27) (Type, F	rint)					

Amended #20b 2/28/95 MRT Montgomero

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. REG. NO. ATE OF DEATH 3. TIME OF DEATN 995 17:34P M ATE OF BIRTH forth, Day, Year) 8. BIRTHPLACE (State or Foreign Wash. DC 9c. COUNTY OF DEATN MONTGOMERY 10d. INSIDE CITY 1 - YES 2 1 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. IIGIN? (Specify Yes or No— irto Rican, atc.) 14. RACE — American Indian, Black, White, etc. Specify: Black 16b. KIND OF BUSINESS/INDUSTRY None rst, Middle, Malden Surname) lumber, City or Town, State, Zip Code) ver Spring, MD 20906

20c. LOCATION — City or Town, State Rockville, MD

AL HOME, P.A. 20850 cardlec or reapiratory arrest,

Approximata interval Between **Onset and Death** 7 days 10 years Disease

24a. WAS AN AUTOPSY PERFORMED?

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 | YES 2 | NO

5 🗆 Residence	6 ☐ Other (Specify)
JRY AT RK? ES 2 NO	28d. DESCRIBE HOW INJURY OCCURED
	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 TYES 2 NO

me,	data	and	place,	and	dua	to th	e ceu	se(a)	and r	nenne	88	stated	s.
pink	on, d	eath	occure	d at	1he	time.	data	and	placa.	and d	un t	o the	CRUSO

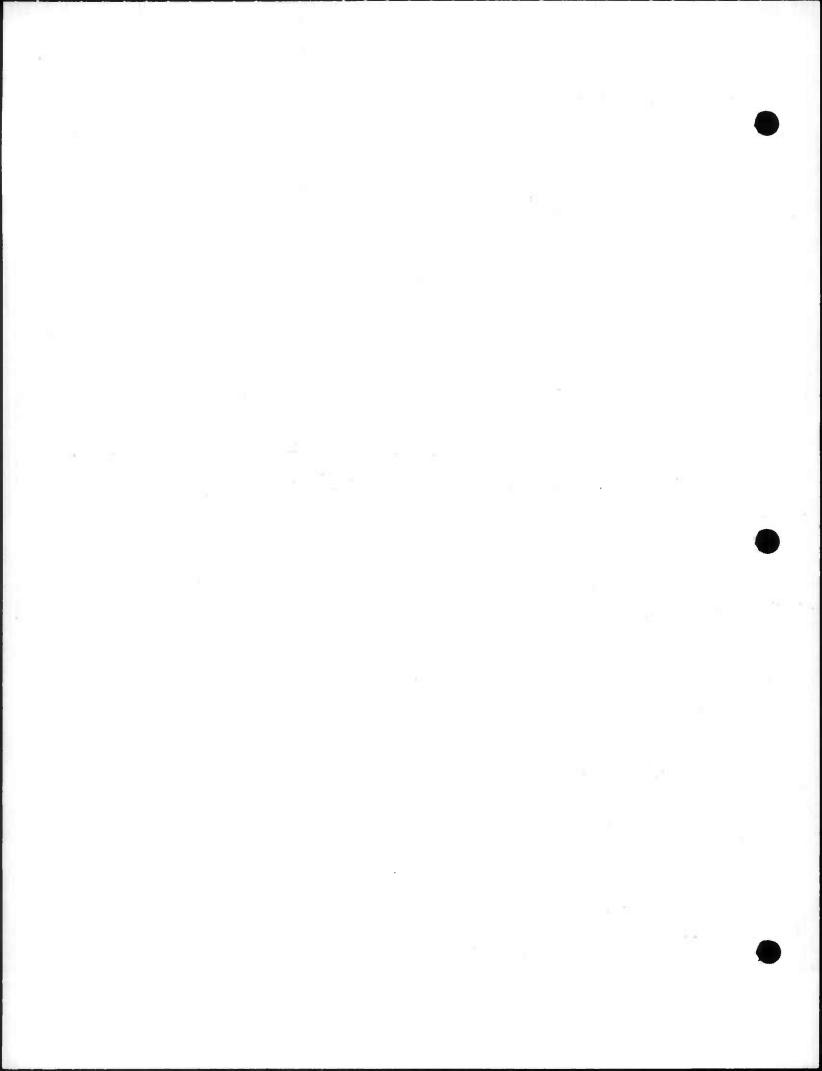
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inion,	destn	occured	at m	e time,	osta	and	placa,	and	dua	to the	Cause(s)	and	manner	88	state	J.

b. SIGNATURE AND TITLE OF CERTIFIER		1 1	29c, LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
([]] ~1	VVIAMAN	W)	THE CHOCKET TOMBER	290. DATE SIGNED (MORITI, Day, 1987)
C SAN TO	1 / VVVVV	V- 1)	1 D13< X3	NT-1 -2 1200
()			1 11/2000	P 125, 23, 1993
	· ·			1001-1

CERTIFICATE OF DEATH

Alfred Munze:	r 7600 C	arroll	Ave.	Takoma	Park	Ma
E FILED (Month Day Year)	22 DECISTRADIS SIGNI	ATHE				

FFB 28 1995 Juli Studior Reviel



OHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

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RECORDS
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DIVISION

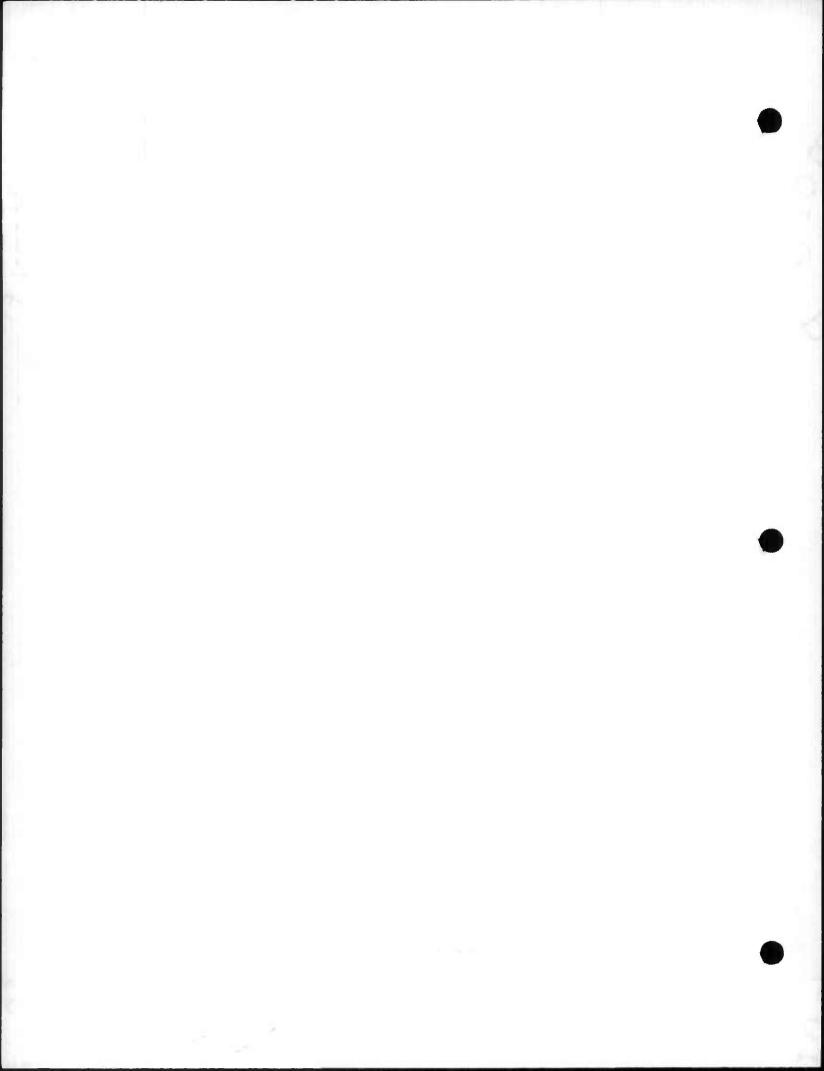
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CER	TIFIC	ATE OF	DEATH	MEHIN	REG. NO	15-		
	1. OECEDENT'S NAME (First, Middle, Last)						2. DATE	OF OEATH			3. TIME OF OEATH
	Wallace	Le	e	Ko	etz1e		Feb	23	19	95	12:05 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. last birti		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		6. BIRTHE	PLACE (State or Foreign
	578-07-6622	1 🔯 M 2 🗌 F	86 v	RS. MC	ONTHS DAYS	HOURS MIN.	Apri	1 1, 1	908	Mary]	and
	9s. FACILITY NAME (If not institution, give s	treet and number)		9	b. CITY, TOWN C	R LOCATION OF				INTY OF DE	
DIRECTOR	Manor Care				Silver	Spring			Mo	ntgo	mery
5	RESIDENCE OF DECEDENT										
B	Maryland Montg				rown on Locat na Park					- 1	10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			akoi					1 ² YES 2 NO		
RA	7217 Cedar Avenue					20912				USAA	HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVED IN 11 S ABMED								
	1 Never Married 2 Married	FORCES? 1 _	YES 2 NO		If yes, spe	ENDENT OF HISP/ ecity Cuban, Mexic	an, Puerto F	77 (Specify Yei Rican, etc.)	ı or No—	Black,	— American Indian, Whita, etc.
ВУ	3 🔀 Widowed 4 🗌 Divorced	ir res, dive way	TON DATES		1 TES	2 NO Spec	elfy:			Specify	White
ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDE	NT'S US	UAL OCCUPATIO	DN .	16b.	KIND OF BU	SINESS/INC	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 8+)			k done during mos etired.)						
MP	8	0	Owne	r/Pi	residen	t		Automo	bile		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N			Surname)		
BE	Charles Koetzle					Lily H					
6	19a, INFORMANT'S NAME (Type/Print)					nd Number or Rura					_
	Wendy Powell		_	_		eet, La	irel,			2070	
	20a, METHOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Rema	oval from State	20b. PLACE AND (cemetery, cremator	ATEOF E	place) O	me of	OATE			City or Tow	
	4 Donation 5 Other (Specify)	SHEEK - C	Gate of	неа	iven Cer	metery	3/3				g, Maryland
	21. SIGNAL OF PUNCHAL SENSAL DE	7/				New Ha				il Fui	neral Home
	(11)-	m			Silve	r Sprin	g, Ma	rylan	d 20	1904	
	23. PART i. Entar the diseases, or o shock, or heart fellure.	complications that o	aused the death.	Do not	anter tha mod	de of dying, su	ch es card	liac or reap	ratory arr	rest,	Approximate
	IMMEDIATE CAUSE (Final	A	4								intarval Batween Onaet end Death
	disease or condition resulting in death)	apuri	un ym	ellune	ma						4 DAYS
		QUE TO (O	OUR TO (OR AS A CONSEQUENCE OF):								
ON	Sequentially list conditions,	yours.	R AS A CONSEQUEN	-							5 Yers
CERTIFICATION	if any, leeding to immediata cause. Enter UNDERLYING	002 10 (0	H AS A CONSECUEN	CE OF):							
FI	CAUSE (Disease or injury that initiated events	DUE TO (O	R AS A CONSEQUEN	CE OF):							-
F	reaulting in death) LAST										İ
DICAL	PART ii. Other significent conditions	s contributing to de	ath but not resul	ting in t	tha underlying	cause given in	Part i.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS
8								1 TYES 2	- NO	- (COMPLETION OF CAUSE OF DEATH?
ME											YES 2 NO
PHYSICIAN: M	DID TOBACCO USE CONTE	RIBUTE TO CAU	SE OF DEATH	YES	□ NO 🖸	UNCERTA	N 🗆				
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF		Check only one) THER:						
YS	1 TES 2 NO	1 Inpetient 2 E				5 🗆 Rasidence	6 🗆 Other	(Specify)			
	27. MANNEP*OF OEATH 1 Natural 5 ☐ Pending	28a. OATE OF IN. (Month, Day,		INJURY	Y WO	RK?	26d. DE\$	CRIBE HOW I	NJURY OCC	CURED	
BY	2 Accident Investigation	00- DI 105 05 I				ES 2 NO					
6	3 Suicida 6 Couldmot ba 4 Homicide determined	building, etc	NJURY — At home, for (Specify)	arm, atrec	et, factory, offica		28f. LOCA	ATION (Street a or Town, State)	ind Number	or Rural Ro	ute Number,
H.	M. 00000000										
MPI	(Check only										
COMPLETED	2 MEDICAL EXAMINE		ntnation and/or invest	igation, i	n my opinion, de	ath occured at the	e time, data	and place, an	d dua to th	a cause(a)	and manner as stated.
BE	299. SIGNATURE AND THE OF CERTIFIER	orthe 0				29c. LICENSE NU	IMBER		29d. DATI	E SIGNED (Month, Day, Year)
2	home of Line	Montery 1	41).			D 248	10		▶ 2	124	195
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (FIEW 27)	(Type, Pri	70.0	min M	0 0	0815-			
	INVICK H. KIG (N.)). 10/ 40		. >	silver S	rung 101	N P	0015			
	31. DATE FILED (Month, Day, Year) FFD 2.7 100F	32. REGISTRAR'S			•	1					
- 11	FFR 4/ 700E	d.1. As	1 0 .	4							



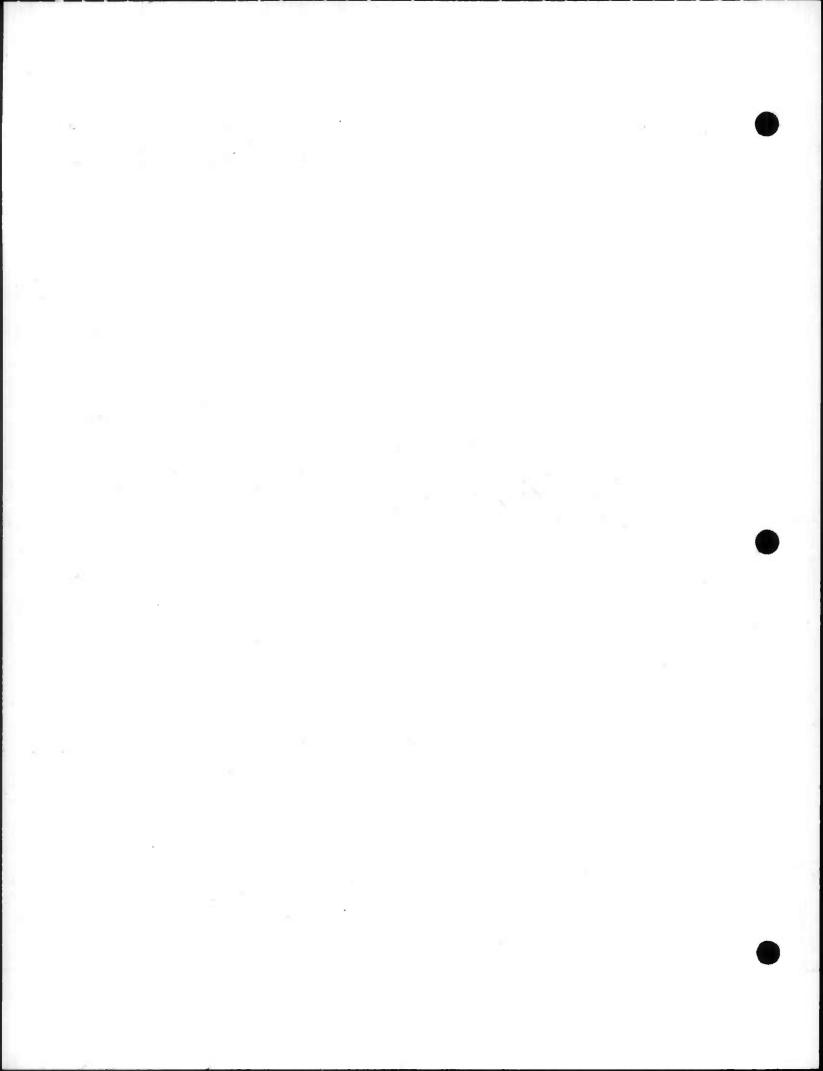
DIVISION OF VITAL RECORDS P.O. BOX 68760

מבר ווויסיור, ווועווי וויעווי בעווס ביבים סססס	merch hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. RELEASED BY DR. JOHN TAUBER, M.E. ed., or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burifal, crem. IMPORTANT: If I tem 28 is marked, or Item 23 shows any injury, or other traumatic event,

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	10a.
	10e.
	11. A
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	17. F
	19e.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND DEATH	MENTAI	HYGIEN REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest) ABRAHAM			KORZE			OF DEATH		YEAR 3.	TIME OF DEATH 9:30 PM M				
	4. SOCIAL SECURITY NUMBER 356-32-7039	March Car March												
R	90. FACILITY NAME (If not institution, give st MONTGOMERY GENE			OLNEY	PR LOCATION OF DI									
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			11011		d. INSIDE CITY				
	MARYLAND MO	NTGOMERY	SI	LVER SP				LIMITS?						
FUNERAL	3310 N. LEISURE	WORLD BLVD.	#602	101	20906					T COUNTRY?				
В	11. MARITAL STATUS 1 Never Merried 2 📉 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	ENDENT OF HISPAI acity Cuben, Mexica 2 NO Specif	? (Specify Yee lican, etc.)	or No 14	American Indian, mite, etc.						
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 1 2	CATION completed) College (1-4 or 8 +)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use of OWNER	k done durina ma	ON st of working	16b.	KIND OF BUS	11/12/12/02/	STRY					
OM	17. FATHER'S NAME (First, Middle, Lest)		OWNER		16. MOTHER'S NA	ME (First, A		CERY Surname)						
BE C		RZEC			FAIGELA		NDYK							
5	190. INFORMANT'S NAME (Type/Print) MARY KORZEC	(WIFE)			RE WORLD					20906 G, MD.				
	20e, METHOD OF DISPOSITION 1 (X Burlel 2 Crementon 3 Plante 4 Donation 5 Donaton)	Cerne JU	PLACEAND DATE OF THE CHARGE OF OTHE DEAN MEMO	DISPOSITION (Na Colece) DRIAL G	ARDENS	2/24		EY, MA						
	21. SIGNATURE OF NUNERAL BERNYCE LIC	In. Hus	4	1170 R	D ADDRESS OF FA SKY-GOLD OCKVILLE	PIK	E-ROCK	VILLE	, MD.	S,INC. 20852				
	23. PART I. Enjoy the diseases of c shock, or heart failure. I	omplications that caused List only one ceuse on ea	the deeth. Do not ch line.	anter tha mo	de of dying, auc	h as cerd	ac or respi	ratory arrea	t,	Approximata interval Between				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Bladder Cancer Due to for as a consequence of:													
NO	Sequentielly list conditions,													
ICATI	If any, leading to immediate cause. Enter UNDERLYING													
CERTIFICATION	that initiated events resulting in death) LAST	J	CONSEQUENCE OF):											
4	PART II. Other significant conditions	contributing to death bu	t not resulting in	the underlying	cause given in	Part i.	24a. WAS AN PERFOR	MED?	CO	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?				
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	PIRLITE TO CALISE OF	DEATH VEC		LINCEDTAN					YES 2 NO				
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	2	6. PLACE OF OEATH	(Check only one)	UNCERTAII	ТД								
IYSI	1 X YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpat	tlent 3 M DOA 4		5 🗆 Realdence	8 🗆 Other	(Specify)							
	27. MANNER OF DEATH 1 X Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO	JRY AT RK? ES 2 NO	28d. DEŞ	CRIBE HOW IN	JURY OCCUP	RED					
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Specif	- At home, ferm, stre	et, factory, office	,		TION (Street e. r Town, State)	teet and Number or Rural Route Number, tate)						
COMPLETED		CIAN: To the best of my knowled.								d menner aa stated.				
BEO	29b. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUN			29d. DATE S	IGNED (Mo	onth, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF OEA	TH (ITEM 27) (Type. Pr	int)	D2360	0		Fra	23	,1995				
	BRUCE R. KESSEL,				JE, SUIT	E 214	- CHE	VY CHA	SE.	MD. 20815				
	FFB 27 1995	2. REGISTRAR'S SIGNAT	CLANC											



itending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within -c4 hours after death. Page 6 may be retained by the hospital or att	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filled within 72 hours after death with the State Deat, of Health and Mental Housene orior to build, committion, or removal	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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31. OATE FILED (Month, Dey, Year)
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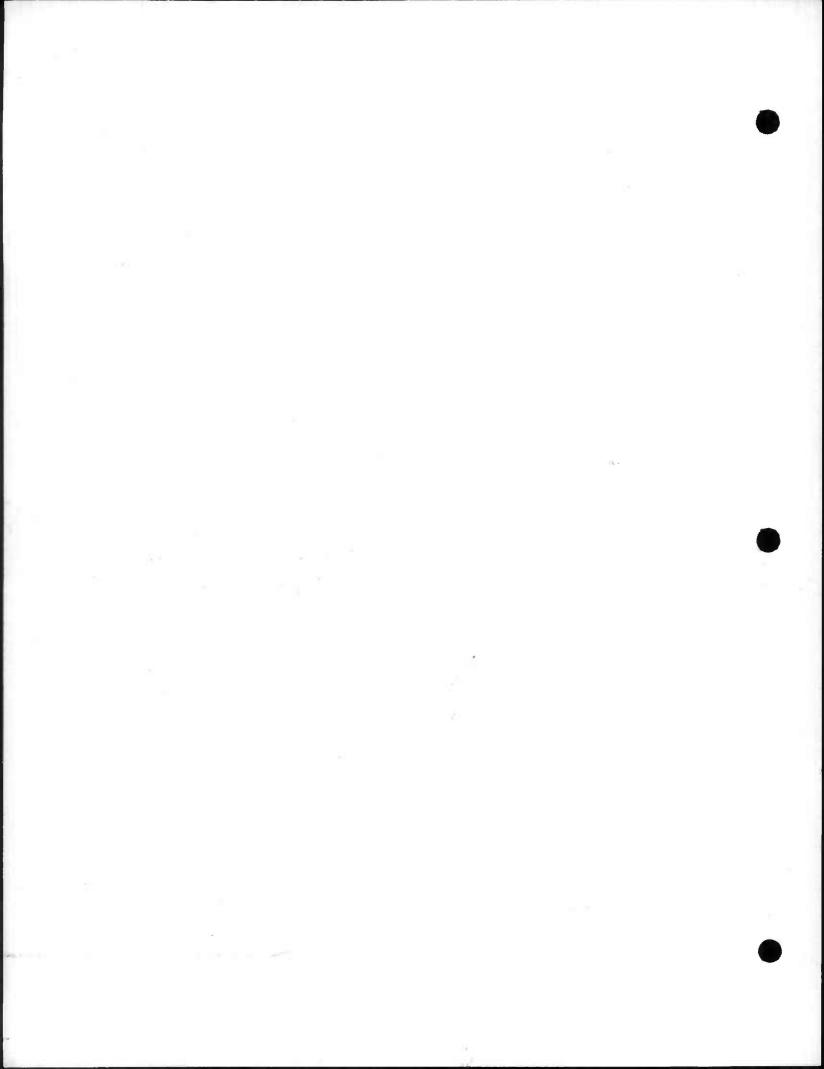
									95	07884			
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPA CERTII										
	1. DECEDENT'S NAME (First, Middle, Lest)		CERTI	ICAI	E OF	DEATI		REG. NO					
	Nik I/A T	5/11/5/1	L			. 1			AY	YEAR 3. TIME OF DEATH			
	WINHAI	SUHELA	Λ	IRM	1AN		J	EBKUARY	27	1995 11:15 4			
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthdey	MONTHS	DAYS	IF UNDER 24	MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTNPLACE (State or Foreign Country)			
	016-64-5398	1 M 2 TF	56 YRS.	MONTHS	DAYS	HOURS		Oct. 10,	1938				
	9a. FACILITY NAME (If not institution, give s	street end number)		9b. CIT	Y, TOWN C	OR LOCATION				NTY OF DEATN			
E E	Washington Adven	tist Hospita	1	Та	koma	Park			Man				
15	RESIDENCE OF DECEDENT	CIBC HOSPICA		1 10	ikoma	Talk			Mon	tgomery			
DIRECTOR	10e. STATE 10b. COUNT	Y	10c. CI	TY, TOWN	OR LOCAT	TION				10d. INSIDE CITY LIMITS?			
<u>a</u>	Maryland Montg	omerv	F	locky	ille					1 X YES 2 NO			
1	10e. STREET AND NUMBER					. ZIP CODE			10a CITI	IZEN OF WHAT COUNTRY?			
2	338 W. Edmonston	Drive				20852							
FUNERAL	11, MARITAL STATUS	12. WAS DECEDENT EVER I	1110 10110	1 40						ted States			
E	1 Never Married 2 Married	FORCES? 1 YES	2 NO	13.	If yes, spi	ecify Cuben,	Mexican,	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-	14. RACE — American Indian, Black, White, etc.			
BY	3 Widowed 4 Divorced	IF YES, OIVE WAR OR D	ATES		1 TYES	2 NO	Specify:	Ť		Specify:			
	15. DECEDENT'S EDU	1		- 1					1	Indian			
Щ	(Specify only highest grade	completed)	16a. DECEDENT' (Give kind of	work done	during mo	ON ast of working		16b. KIND OF BUS	SINESS/INC	DUSTRY			
اتا	Elementary/Secondary (0-12)	College (1-4 or 5+)			,								
M	12		Homema	ker				Home					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTNE	R'S NAME	E (First, Middle, Meiden	Sumame)				
BE	Ali Kamil Kidwai					Unkno	own	Sadya					
0	19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRES	SS (Street a	nd Number or	ute Number, City or Tow	Town, State, Zip Code)					
۱۴۱	Uruj A.S. Kirman	i	338 W	. Ed	mons	ton Di	rive	. Rockvil	le. N	Maryland 20852			
	208, METHOD OF DISPOSITION	200	PLACE AND DATE							City or Town, Stata			
	1 Donation 6 Other (Specify)	loval from State can	netery cremetory or	other plane	1		t 0 10 11 1	1		Maryland			
1 1	21. SIGNATURE OF PUNERAL SERVICE LIC	CENDER O	corge wa	22	NAME AN	D ADDRESS	OF FACIL	LITY AGE	TDUI,	Maryland			
	1 5	H						Funeral H	ome.	Inc.			
	11800 New Hampshire Ave., Silver Spr												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,												
	iMMEDIATE CAUSE (Final	clat only one cause on a	ach lina.	interval Between Onset and Death									
	disease or condition	Mygrach	101 -										
	reaulting in death)	DUE TO (OR AS /	CONSEQUENCE	OFI:	1000	chi							
- 1													
ERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
A	If any, leading to immediate cause. Enter UNDERLYING			. ,.	,	(
[윤]	CAUSE (Disease or injury that initiated events	CDUE TO (OR AS /	CONSEQUENCE (ne.									
Ē	resulting in death) LAST			. ,.						į .			
병		d											
_	PART ii. Other aignificent condition	a contributing to death b	ut not requiting	in the u	nderlying	cause giv	ren In Pa	art i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS			
MEDICAL	OSTROMUR	itie				_		PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
								1 YES 2	NO	OF DEATH?			
	DID TODA 660 HER 664									1 TES 2 NO			
z	DID TOBACCO USE CONT	RIBUTE TO CAUSE O				UNCE	RTAIN						
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF OE/	OTHE									
YS.	1 TES 2 NO	1-2 Inpatient 2 - ER/Outp	patient 3 🗆 DOA			e 5 🗆 Resid	dence 6	Other (Specify)					
표	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TII	WE OF	28c. INJU	URY AT RK?	2	ad. OEŞCRIBE NOW II	NJURY OCC	CUREO			
ВУ	1 Netural 5 Pending 2 Accident investigation			M		ES 2 P	NO						
0	3 Suicide 6 Could not be	28e. PLACE OF INJURY	- At home, ferm,	street, fed	tory, office		2	er. LOCATION (Street e	nd Number	or Rural Route Number,			
W I	4 Nomicide determined	building, etc. (Spec	eny)					City or Town, State)					
LET	290. CERTIFIER CERTIFYING PAYER	CIAN: To the heat of an	ladas de et										
COMPL		CIAN: To the best of my know											
8				on, in my	opinion, de	wath occured	at the fin	ne, date and place, en	due to th	e cause(s) and menner as stated.			
w	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENS	SE NUMBE	ER	29d. DATE	E SIGNED (Month, Day, Year)			
OB	1-Jack 1 A	122 M					36	704 1		4/27/95			
ΙĔΙ	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH /ITEM 27) /Sec	o Drinti	- /								

OMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jaz. REGISTRAR'S SIGNATURE

Tatom

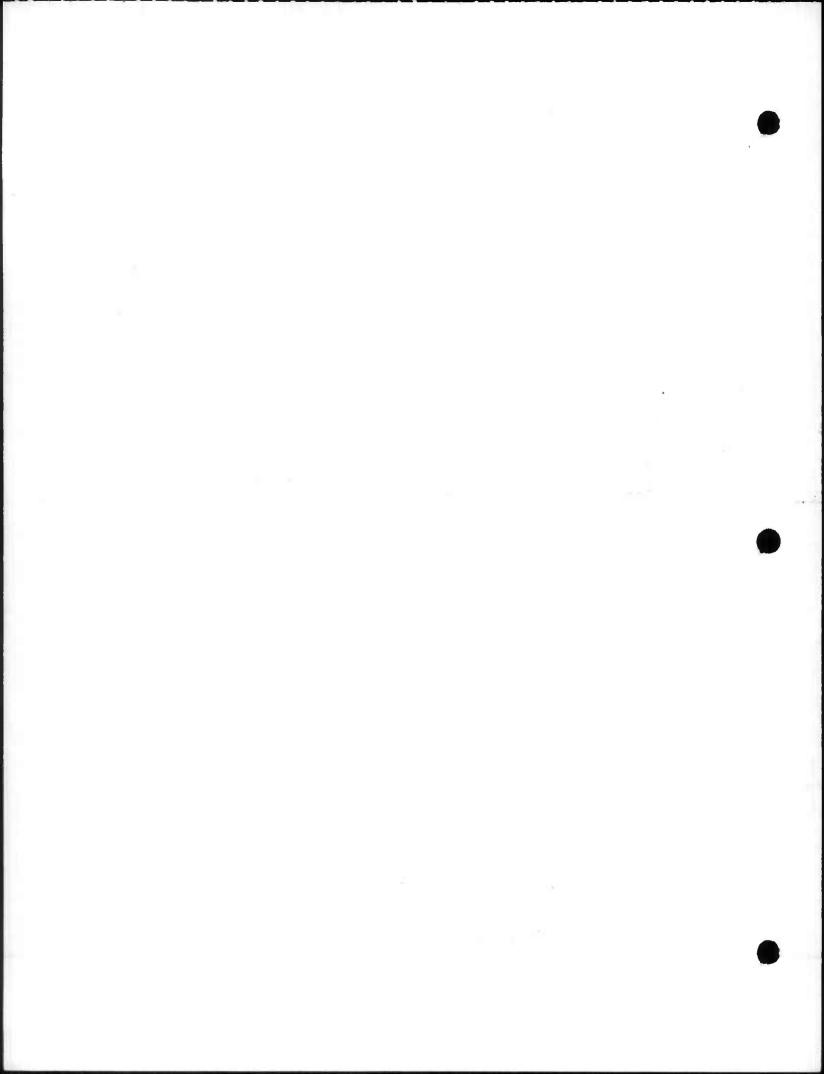
ospita



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First,	Middle, Lest) Lin	в. к	lum					2. DATE OF MONTH Feb.	DEATH DA	, 199		3. TIME OF DE 8:15	
		4. SOCIAL SECURITY NUMBI		5. SEX		s. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF				PLACE (State or	P M
		103-50-5789		1 🕅 M 2 🗆 F	4		MONTHS	DAYS	HOURS MIN.	Oct.	my, Ybar)	1952	Guy)	roreign
3 should		9a. FACILITY NAME (If not ins		reet and number)			9b. CITY	, TOWN	OR LOCATION OF D		19,	9c. COUN			
2,	DIRECTOR	4502 Mahan					WI	neat	on			Mont	gome	ry	
Des 1) 	10a. STATE	10b. COUNTY			10c. Cf	TY, TOWN	OR LOCA	TION				10d. INSIDE CI	ITY	
£.		Maryland	Montg	omery		Wh	eator	n						LIMITS?	□ NO
med 1	341	10e. STREET AND NUMBER	n 1						1. ZIP CODE			10g. CITIZ	EN OF WI	HAT COUNTRY	7
ian. transi	FUNERAL	4502 Mahan	Koad	40 400 0505050					20906					tates	
physician. burial-transit permit. Pages 1,		1 Never Merried 2 🔲		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	X YES 2	□ NO	- 1	If yes, sp	CENDENT OF HISPAI Decity Cuben, Maxics 3 24 NO Specific	in, Puerto Rica	specify Yes n, atc.)	or No-	Black,	— American in White, alc.	ndian,
	B	3 Widowed 4 Divor	ced	1977-19		•		1 YES	S 24 E NO Specif	у:			Specify Bla		
or attending ir use as the	TE		DENT'S EDUC highest grade		164	. DECEDENT'S	work done	CCUPATION TO THE COURT OF THE C	ON ost of working	16b. KII	ND OF BUS	SINESS/INDU	STRY		
by the hospital or att be detached for use at once.	COMPLET	Elementary/Secondary (0- 12	12)	College (1-4 or 5 -		Ille. Do NOT t	ise retired.)			n .	7 7 A	. 7			
the host detache	MO	17. FATHER'S NAME (First, Mic	ddle, Last)		As	ssista	nt Te	chn	1Clan 18. MOTHER'S NA			tlant	1C		
		Ronald Kum							Ethel		ra, Marcian	Surname)			
retained 5 should notified	BE C	19a. INFORMANT'S NAME (Ty	pe/Print)			19b. MAILIN	G ADDRES	S (Street a	and Number or Rural		City or Tow	n, State, Zip (Code)		
	유	Patricia Ku	m			4 Vi	ctor	Roa	d, Beaco	n, New	Yor	k 12.	508		
ter death. Page 6 may be the funeral director, page yval.		20a. METHOD OF DISPOSITION 1 A Burlal 2 Cremation	3 🗌 Remo	oval from State	20b. PL/	ACE AND DATE	OF DISPOS	SITION /N	ame of	DATE		CATION — C			
Page 6 d direct		4 ☐ Donation 5 ☐ Other (FNSEE	Par	Klawn				3/4	Roc	kvill	e, Ma	arylan	d
death. Pag tuneral di i. examiner		. ()		gu.	we-	Ň	ic Gu	nd address of fa	ral Se	rvic	e, In	с.	200	
after death. y the funeramoval. cal exami		aynn	e o	7.00	1		7	400	Georgia	Ave.	N.W.	, Wasl	ning	ton, D	.C.
filled in by the on, or removal		23. PART i, Enter the dis ahock, or he	art failure. I	omplicatione that list Dnly one cau	t caused the	e deeth. Do iine,	not enter	tha mo	ode of dying, auc	h as cerdisc	or respi	ratory arre	st,	Approxi intarvai	mate Between
E 8 E		iMMEDIATE CAUSE (Fine disease or condition	pi N	Dana	wooti.	Come								Onset a	nd Death
completely fille ial, cremation,		reaulting in death)	7			NSEQUENCE O									
and com o burial,	Z		200	0,										į	
ie be execute sician and c arior to buria traumatic	AT 10	Sequentielly list conditions, If any, leeding to immediate cause. Enter UNDERLYING													
phy phy	FIC.	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):													
uires that the death certificate signed by the attending physic Health and Mental Hygiene pri we any Injury, or other the	CERTIFICATION	resulting in deeth) LAST													
the deat y the atto d Mental		PART II. Other significer	t condition	contributing to	death but n	ot resulting	in the ur	derlyin	a cause alvan In	Part i a	- 1400 441	ALCTORAL	Land		
that the led by the lith and Manager Injury	EDICAL	PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given									PERFORMED?			24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE	
requires to signer of Health	E							_ 1	YES 2	MO NO	(OF DEATH?			
of of	¥ ::	DID TOBACCO US	E CONTR	RIBUTE TO CA	USE OF D	DEATH Y	ES 🗆 I	NO F	UNCERTAIL	$\overline{\Box}$			'	1 YES 2] NO
SICIAN: The law certificate has b to the State Dept. 1, or Item 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		PLACE OF DEA	TH (Check	only one)					_		
CLAN: certifical the Sta	YSI	1 TYES 2 NO		1 inpatient 2	ER/Outpatier	nt 3 🗆 DOA	OTHER	R: Bing Hom	ne 5 AlesIdence	8 🗆 Other (Sp	pecify)				
this with	у РНУ	27. MANNER OF DEATH	ending	28a. DATE OF (Month, D	ay, Year)	28b. TIR	ME OF JURY M	WC	URY AT DRK? YES 2 NO	28d. DESCRI	BE HOW II	NJURY OCCU	IRED		
OR ATTENDING F DIRECTOR: After I hours after death Item 28 is mar	ED BY	3 Suicide 8 C	ould not be	28a. PLACE D building,	F INJURY — A atc. (Specify)	At homa, farm,	street, lact	ory, offic		281. LOCATIE City or To	ON (Street a own, State)	and Number o	r Rural Ro	ute Number,	
DIRECTOR: hours after Item 28 is	Ē	29a. CERTIFIER	TUNG BUNGU	- Parling to the	a call frague		NAD I								
7 70 =	COMPLETED								and place, and due leath occured at the					and manner as	stated.
HE HO HE FUI BO WITH	BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER	-	4	10			29c. LICENSE NUI	48ER		29d. DATE	SIGNED (Month, Day, Yea	ır)
TO THE HOSPITY TO THE FUNERA De filed within 7 IMPORTANT: I	TO B		ARLE	5 7	. \	75-			D-31920)		► Ma	rch	2, 199	95
		30. NAME AND ADDRESS OF							20.71						
20		Charles J.			R'S SIMI ATUE	WOLTE	Stre	et,	Blalock	606, I	Balti	more,	MD	21287	7
		MAR 03 19	95 8	32. REGISTIVA	ion hand	all									



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIM	E OF DEATH
MARY I I AMPE AMPE FEBRUARY 26, 1987 O	425 M
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month Day Mar)	(State or Foreign
215-44-1083 1 M 2 SF 50 YRS. 9-28-44 D.C.	
96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH	
PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT	
	SIDE CITY MITS?
MORCESTER BERLIN	ES 2 NO
106. STREET AND NUMBER 17 EAST WIND DRIVE 107. ZIP CODE 21811 108. CITIZEN OF WHAT CO	UNTRY?
1 Never Merried 2	ricen Indien, etc.
	HITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	
Elementary/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) HOMEMAKER OWN HOME	
17. FATHER'S NAME (First, Middle, Last) DONALD S. KIMBALL LUCILLE SADLER	
19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
JAMES O. LAMPE 17 EAST WIND DR., BERLIN, MD., 2181	
20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of OATE 20c. LOCATION — City of Town See	
1 Buriel 2 Cremetion 3 Removal from State Cemetery, cremetory or other place SALISBURY CREMATORY 2-29 SALISBURY	ID.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	
ULLRICH FUNERAL HOME BERLIN	Mp.
23. PART 1. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or resolutions arrest.	pproximate
strock, or naert failure. List only one cause on aach lina.	nterval Between
disease or condition resulting in death) •. Vm / rodg (m's lym/homa, Wichlen	
DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, a common with the sequential of the	
if any, leading to immediate cause. Enter UNDERLYING	
CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):	
reaulting in death) LAST	
DADY II Other significant conditions and it is	
PERFORMED? AVAILA	UTOPSY FINDINGS BLE PRIOR TO
1 □ YES 2 ₽ NO COMPL	ETION OF CAUSE TH?
	ES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	
EXAMINER? 1 YES 2 NO HOSPITAL: OTHER: OT	
27. MANNER OF GEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED	
1 Netural 5 Pending (Month, Dey, Year) INJURY WORK? 2 Accident Investigation (Month, Dey, Year)	
3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)	nber,
4 Homicide determined	
29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.	
(Check only Check only Check only Principles of the best of my knowledge, death occurred et the time, data and place, and due to the cause(a) and manner as stated.	
(Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.	inner as stated.
2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and m 29b. SIGNAULI OTITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D 2-0.50.7) 27.76/10	
2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(e) and multiple of title of certifier 29b. SIGNAUIII O TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, DONE) OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and m 29b. SIGNAULI OTITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D 2-0.50.7) 27.76/10	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

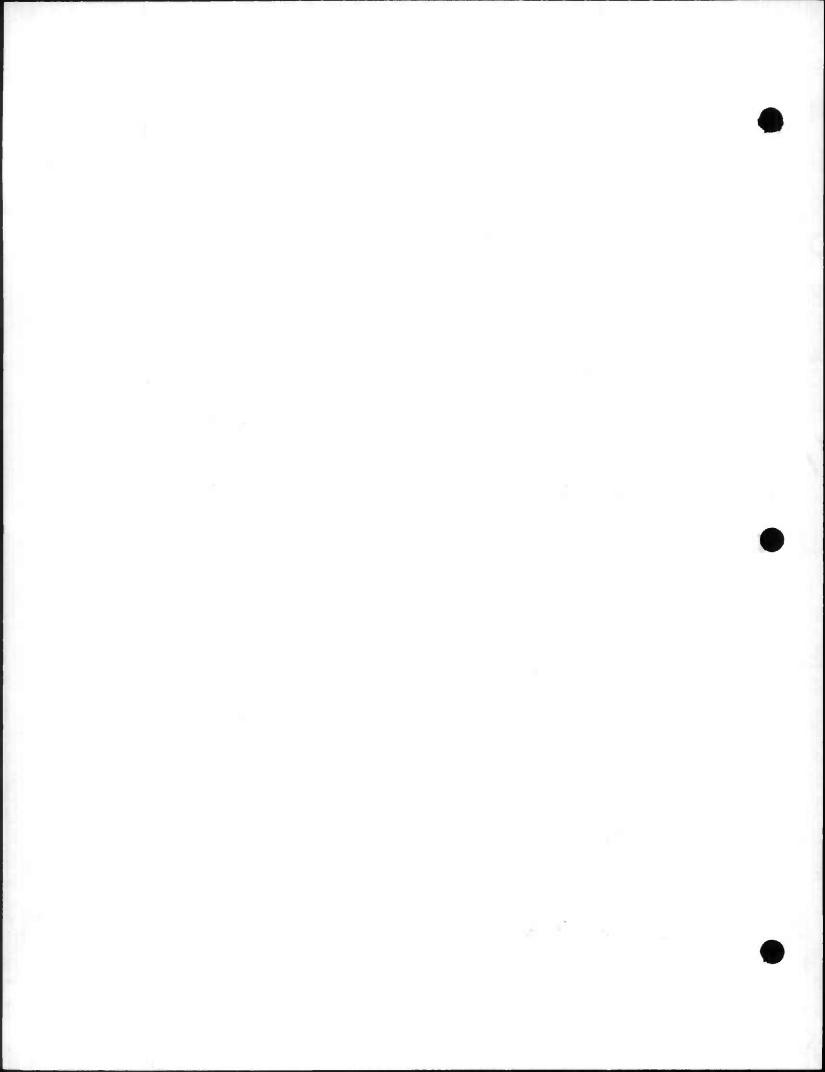
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF H	HEALTH AND DEATH	MENTAL HYGIEI							
	1. DECEDENT'S NAME (First, Middle, Last	ade				2. DATE OF DEATH	DAY YEA	3. TIME OF DEATH					
	NELL T	SYNCH				FEBRUARU	25 9						
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 21	- C	RTHPLACE (State or Foreign					
	220-18-1308 90. FACILITY NAME (If not institution, give		13 YRS.		2001		1901 Ma	aryland					
	Washington Count				erstown	EATH	Washing						
CTOR	RESIDENCE OF DECEDENT						Washiin						
DIRE	10a. STATE 10b. COUN		10c, CIT	TY, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?					
	Maryland Wa	shington		Hagerst	ZIP CODE			1 TYES 2 NO					
FUNERAL	11331 Youngstoun	Drive		101	21742	2	1	S.A.					
١	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Ve		ACE — American Indian,					
- 1	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 TYES			ecify Cuben, Mexics 2 X NO Specifi	in, Puerto Ricen, etc.) y:		lack, White, etc.					
	15. DECEDENT'S ED	UCATION	16. DECEDENT'S	USUAL OCCUPATION	N	40. 200 05 0		White					
	(Specify only highest grad Elementary/Secondary (0-12)	fe completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during mo	st of working	166. KIND OF BU	JSINE\$S/INDUSTR	Y					
	12	0	Hon	nemaker		Her o	wn home						
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meider							
	Joseph F. Sensen	baugh				llen Hornb							
2	190. INFORMANT'S NAME (Type/Print) Richard H. Lynch					Route Number, City or Tov		Md. 21795					
ł	20a METHOD OF DISPOSITION	201	. PLACE AND DATE				OCATION - City of						
	1 Surlet 2 Cremation 3 Rei	moval from State cen	netery, crematory or o	ther place) National	Cemeter	V 3-1-95	Baltimor	e, Maryland					
1	21. SIGNATURE OF FUNERAL SERVICE L		- 1	22. NAME AN	ID ADDRESS OF FA	CILITY Minnic	h Funera	al Home					
	> Scott	WY Yun	ruch					Md. 21740					
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Approximate Interval Between												
	iMMEDIATE CAUSE (Finel	. List only one cause on e	ach line.					Interval Between Onset and Death					
	disease or condition reaulting in death)	· PNEUMO	NIA					4 DAMS					
		DUE TO (OR AS A	CONSEQUENCE O	F):									
ILICATION	Sequentially list conditions,	b DUE TO (OR AS A	CONSEQUENCE O	F):									
	if any, leading to immediate cause. Enter UNDERLYING	c		.,.									
	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):									
	resulting in death) LAST	d											
	PART II. Other aignificant condition	ns contributing to deeth b	ut not resulting	in the underlying	ceuse given in	Part I. 24s, WAS AN	AUTOPSY :	1 24b. WERE AUTOPSY FINDINGS					
	ANTENIOSCIENST	YC HOTAT	DISERS	5 WATH	CNSMBC	PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE					
	ANTINA MADO CO	N GSTIVE CH	ANAC F	MUNE	-			OF DEATH?					
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S NO		v 🗆							
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:									
	1 YES 2 NO	1 Inpatient 2 ER/Outp	etient 3 DOA			6 Other (Specify) 28d. DESCRIBE HOW							
	1 Netural 5 Pending	(Month, Day, Year)	INJ	URY WO	RK?	200. DESCRIBE HOW	INJUNY OCCURED						
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, factory, office		26f. LOCATION (Street	end Number or Run	al Route Number,					
	4 Homicide determined	and in the latest the				City or Town, State,)						
		SICIAN: To the best of my know											
	one) 2 MEDICAL EXAMIN	ER: On the baels of examination	n end/or Investigation	n, In my opinion, de	eath occured at the	time, date end place, er	nd due to the seus	e(e) end manner es stated.					
Ш	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUN			ED (Month, Day, Year)					
	30. NAME AND ADDRESS OF PERSON W	no			D01040	<u> </u>	► 02-2	6-95					
	12 0 0 0						2 . ~						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	Day He	toenstoe	way MD	217 KL						
	FEB 2 - 1995 Jal	Abrilen Rad											
		The second second											

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

A SCAL SECURITY NAME OF CORRESPONDED ASSET AS A CONSTRUCTION OF STATE AS A													
SOCIAL SECURITY NAMES (FIRST ANAMAGE) 1. W 2 (R F 68 MB. MONTHS) 1. SECURITY NAMES (FIRST ANAMAGE) 1. SECURITY NAMES (ME OF OEATH												
220-18-2057	17514												
Se. PRACHITY NAME (if not notation, pive steep and number) Washington County Hospital RESIDENCE OF DECEDENT Washington County Hospital RESIDENCE OF DECEDENT Washington Maryland Washington Washington Maryland Washington Maryland Washington Maryland Washington Maryland Washington Maryland Washington Maryland Washington Maryland Washington Washington Maryland Washington Washington Washington Washington Washington Maryland Washington Washington Washington Washington Washington Washington Washington Washington Maryland Washington													
Washington County Hospital Hagerstown Washington Washington Washington Washington Washington Washington Washington Washing	ylvania												
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30 NAME AND ADDRESS OF PERSON WHO COMPLETED OWNER OF DEVIA WELL OF	7												
George E. Way, ND, , 324 E Antietam St, Suite 203 Hagerstown	MD												



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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR				CERTI	FICATE (OF DEATH		REG. NO).			
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OR ATTENDING DIRECTOR: Atter hours after death item 28 is ma	<u> </u>													
AL DIRE 72 hours 11 item	COMPLETED	(Check only	FYING PHYSI	CIAN: To the best o	f my knowl	ledge, death occur	red at the time,	deta and place, and due	to the ca	use(s) and mai	nner as stated.			
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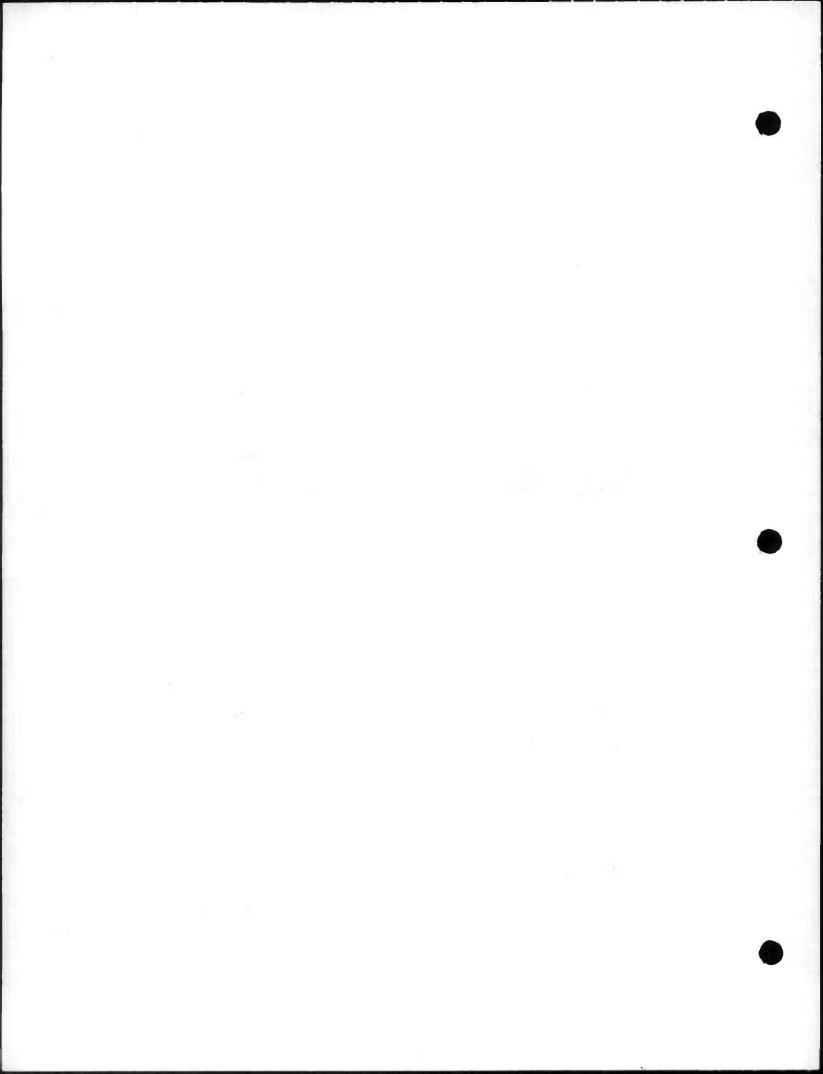
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CEH	HILL	AIE	UF	DEA		- 1	REG. NO.			
	t. DECEDENT'S NAME (First, M		od Howho		Toro						2. DATE OF	D/		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		ed Herbe 5. SEX		(In yrs. lest bir	thday) II	F UNDER 1	YEAR	IF UNDER	24 HRS.	Feb 22		5	8 BIRTHE	8:35 P M
	193-05-56	585	1 M 2 F		Q /I			DAY8	HOURS	MIN.	June	my. Yeur)	110	Country)
	9e. FACILITY NAME (If not instit	ution, give stre	et and number)			9	b. CITY, T	OWN C	OR LOCATE	ON OF DE		3,13		NTY OF DE	nsylvania
חווחבתום	Fort Washington Hospital							96. CITY, TOWN OR LOCATION OF DE.					Dr	ince	George's
	RESIDENCE OF DECE					igu	11		1 11.	IIICC .	GCOTGC 3				
		Ob. COUNTY			1		TOWN OR								10d. INSIDE CITY LIMITS?
_	Maryland I	rince	George'	S	I	Dist	rict	_	ight				_		1 YES 2X NO
	6506 Kipling	PKWY						101	. ZIP CODI						HAT COUNTRY?
	1t. MARITAL STATUS		12. WAS DECEDEN	FVED	NIIS ADME		1 12 144	O DEC	207		IIC ORIGIN? (S				States
i	1 Never Married 2 Ma	nrried	FORCES? 1 IF YES, GIVE W	YES	27 NO	,	If y	yes, sp	ecify Cube	n, Mexica	n, Puerlo Rice		or No-	Black,	- American Indian, White, etc.
1	Widowed 4 Divorce	d	IF TES, GIVE W	An ON D	ALES	1 □ YES 2 X NO Specify					<i>'</i> :			Specify Whi	
	15. DECED (Specify only h	ENT'S EDUCA			18a. DECED	ENT'S US	SUAL OCC	UPATIO	ON of working	107	16b. KI	ND OF BUS	SINESS/IND	USTRY	
TO BE COMPLET	Elementary/Secondary (0-12	1	College (1-4 or 5 +)	IIIe. Do	(Give kind of work done during most of working life. Do NOT use retired.) Sales Agent					Tne	suran	70		
	8th				Sares	s Age									
	17. FATNER'S NAME (First, Midd James Lego		18. MOTNER'S NAME (First, Middle, Maiden Surname)												
	2	105.44	A II 1010 A F					Nale							
	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												E2		
	Patricia Gallagher 8336 Forrester Blvd, Springfield, Va 22152														
	20s. METHOD OF DISPOSITION 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. LOCATION — City or Town, State 20s. PLACE AND DATE OF DISPOSITION (Name of Feb 25, 1935) 20s. PLACE AND DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE														
1	21. BIGNATURE OF FUNERAL SERVICE UCHTSEE 22. NAME AND ADDRESS OF FACILITY OF FUNERAL HOME, Inc 6												Trc 6633		
	Old Alexander Ferry Road, Clinton, Md 20735														
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate														
	enock, or nea	rt fallure. Li	st only one cau	se on a	ach iine.	. 50		10 1110	de or dy	iry, addi	i da colulec	or respi	raiory err	ost,	interval Between
- [IMMEDIATE CAUSE (Finel diseese or condition resulting in death) a. Cardiac Arrest												Onset and Death		
	resulting in death)	a.			A CONSEQUE										
	Sequentielly list conditions. Congestive Heart Failure														
	If any, leading to immediate														
1	couse. Enter UNDERLYING CAUSE (Disease or Injury - Hypertensive Cardiovascular S Disease												-		
orum icanion	resulting in death) LAST														
	Diabetetes Mellitus, Black Lung Pneumoconiosis														
											WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
	Venous I	1 YES 2 NO						COMPLETION OF CAUSE							
M											1 YES 2 NO				
	DID TOBACCO	USE C				OF I	DEATH	<u> Y</u>	ES 🗆	NO					
PHTSICIAN:	25. WAS CASE REFERRED TO I EXAMINER?	_	HOSPITAL:				THER:	26. PL	LACE OF D	EATH (Che	ock only one)				
2	1 YES 2 NO		1 Inpatient 2			DOA 4	☐ Nursin			sidence	8 Other (S				
	1 Natural 5 Pe	nding	28a. DATE OF (Month, Da		20	Bb. TIME C	77	WO	URY AT	7 410	28d. DESCR	IBE HOW I	NJURY OCC	CURED	
	2 Cutates —	estigation	28e, PLACE OF	rauluri a	Y — At home	form stre			YES 2	NO	281 LOCATIO	M /Stmat s	and Mumbar	ne Grand Go	nuto Mumbas
	_ 0 _ 00	uld not be ermined	building,	etc. (Spe	icify)	101111, 0410	n, street, factory, office				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	29a. CERTIFIER	VINC BUVEIC	AN: To the heat of		alada da da										
	one)		AN: To the best of On the basis of ea												and manner as stated.
- 11	295 BUDNATURE AND TITLE OF				- 1		,					piaca, an			
1	TRAPILE	-			Sh	-	1 //		Do 7	287	REER		29d, DATI	SIGNED	Month, Day, Year)
	30. NAME AND ADDRESS OF P	ERSON WNO	COMPLETED CAUS	E OF DE	EATHLITEM 21	O (Spe. Pr	100		100	20,				72	670
	11418 Living							207	744						
	31. DATE FILED (Month, Day, Yes	ir)	32. REGISTRA												
	FFB 2	8 1995	Station	dilux	allor ha	Malle									

MARTEAN	retained by the hos	5 should be detache	notified at once.
DALI IMORE, MARTLAN	death. Page 6 may be	funeral director, page	xaminer must be
î	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
.O. DO .O.	certificate be executed	ding physician and con lygiene prior to burial.	other traumatic en
DISTRICT OF THE PERCENTS, F.O. BOX 08100	equires that the death	en signed by the atten- of Health and Mental H	hows any injury, or
מו אווערי	PHYSICIAN: The law r	this certificate has be with the State Dept.	ked, or item 23 s
	ITAL DR ATTENDING I	RAL DIRECTOR: After 72 hours after death	If item 28 is mar
	TO THE HOSP	TO THE FUNE	IMPORTANT

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TIMENT OF		MENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Last)	4				2. DATE OF DEATH		3. TIME OF DEATH
		DUAL B. AGE /			1	03 3	3 9:	5 538 "
1		1 M 2 F	In yrs. lest birthday)	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give stre	et and number)	40 YRS.	9b. CITY, TOWN	OR LOCATION OF D	9-23-54 EATH	9c, COUNTY	irginia OF DEATH
DIRECTOR	Anne Arundel Med	dical Cent	er		napoli			Arundel
RE	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
	Maryland Anne	Arundel	An	napolis				1 TYES 2 NO
RA	122 Spa Drive			10	A. ZIP CODE		-17	OF WHAT COUNTRY?
FUNERAL		12. WAS DECEDENT EVER II	U.S. ARMED	13. WAS DE	21403	NIC ORIGIN? (Specify Ye	USA Or No — 14.	RACE — American Indian.
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		It yes, s		an, Puerto Rican, atc.)		Black, White, etc. Specify:
	A CONTRACTOR OF THE CONTRACTOR							white
TE	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	16e. DECEDENT'S (Give kind of life. Do NOT u	WORL OCCUPATI Work done during m se retired)	ON ost of working	16b. KIND OF BU	SINESS/INDUST	RY
P	Elementary/Secondary (0-12)	College (1-4 or 5+)	Music			Mus	io	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)		nasio	Lan	16. MOTHER'S N	AME (First, Middle, Maiden		
BE C	Robert Dale Loud	ler			Mary	K. Sinni	nger	
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow	m, State, Zip Coc	ie)
	Karen Louder			as # 1				
	20a. METHOD OF DISPOSITION 1 □ Buriel 2 □ Cremation 3 □ Remov. 4 □ Donation 6 □ Other (Specify)	al from State cem	PLACE AND DATE etery, crematory or o	ther place)			CATION — City	
1	21. SIGNATURE OF FUNERAL SERVICE LICES	MISEE	etro C	remator 22. NAME A	y 2-	24-95 Cat	onsvi	lle, MD
	1 Rod \$5-1	\geq	1	Barra	nco an	d Sons Fu	neral	Home
\vdash	23. PART i. Enter the diseases, or con	molications that course	the death. Do	495 R	itchie	Hwy Seve	rna P	ark MD 21146
	23. PART i. Entar the diseases, or complications that ceused tha death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate interval Between							
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. CENEANOL IAM MACE Due TO (OR AS A CONSEQUENCE OF):							
	resulting in death) a.				1. 1. 1012			
Z	Sequentielly list conditions, b.	HBMG	PHILIX	9				
PA	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):				
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):				
CERTIFICATION	resulting in death) LAST							
0	PART II. Other significant conditions	contributing to death b	ut not resulting	in the underlyin	a ceuse alvec in	Part i. 24a, WAS AN	AUTOROV	AAL MEDE ALEXANDER CHARACTER
<u> </u> ₹		Total Bottle Country to Country B	at not resulting	in the underlyin	g ceuse given ii	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
9						1 TYES 2) Defino	OF DEATH?
2	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YI	S NO E	UNCERTAI	N [5]		1 YES 2 NO
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEA	, , , , , ,				
YSI	1 TYES 2 NO	Inputient 2 ER/Outp	atlent 3 🗆 DOA	OTHER: 4 - Nursing Hon	ne 5 🗆 Residence	6 Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	26b. TIN	URY WO	JURY AT ORK?	26d. DESCRIBE HOW	NJURY OCCURE	iD .
BY	2 Accident Investigation	280. PLACE OF INJURY	As borns down		YES 2 NO			
윤	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spec	— At Hollie, fellin,	street, sectory, offic		26t. LOCATION (Street City or Town, State)	and Number or R	urel Route Number,
COMPLET	290. CERTIFIER A CERTIFYING PHYSICIA	AN: To the best of my knowl	adas doub assume	and and other offers and other			200.00 U.S.	
OMP								use(s) and menner as stated.
ECC	296. SIGNATURE AND TITLE OF CERTAFIER	,			29c. LICENSE NU			NED (Month, Day, Year)
00	Aty / Wolling	ndr.			D081	18	D 2/	UY/ST
10	STANURY WA	COMPLETED CAUSE OF DE	SUITED SUITED	Print) 300 SC	10 BEST	GATE RO	ANN	gouls mo
	FEB 27 1995	32. REGISTRAR'S SIGN					901711	21481
	The state of the s							



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REGISTRAR		CERTII	FICATE O	DEATH	REG	NO.		
1. DECEDENT'S NAME (First, Middle,	Last)				2. DATE OF DEAT	гн		3. TIME OF DEATN
LILLI	AN M. LA	RMORE			Februar	TAY 24	1995	6:45 p
4. SOCIAL SECURITY NUMBER		. AGE (In yrs. lest birthday	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	N .	8. BIRTH	PLACE (State or Foreign
220-05-3467 90. FACILITY NAME (If not institution,	1 🗆 M 2 🕞 🗐	96 YRS.	4 1 18	3	October	6, 1898		land
		Center	Salisl	OR LOCATION OF COULTY	DEATH		COMIC	
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSID						10d. INSIDE CITY		
Maryland	Wicomico		Salist		1 TES 2 NO			
Salisbury Nursing & Rehab. Center Salisbury 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CIT LIMITED 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CIT LIMITED 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CIT LIMITED 10e. STATE 10b. COUNTY 10d. INSIDE CITY STATE 10								
	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPA FORCES? 1 YES 2 NO If yes, specify Culpan, Mexic.					y Yes or No-	14. RACE Black	— American Indian, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR	R OR DATES	1 🗆 YE	S 2 NO Speci	fy:		Specifi	ite
15. DECEDENT (Specify only highest	grade completed)	t6a. DECEDENT' (Give kind or	'S USUAL OCCUPAT f work done during in use retired.)	TION nost of working	CAMPAIN S	BUSINESS/IN		
Elementary/Secondary (0-t2)	College (t-4 or 5+)		lespers			cail S velry	ales	5
15. DECEDENT' (Specify only highest Elementary/Secondary (0-12) 1.7. FATNER'S NAME (First, Middle, La	st)		1000010		AME (First, Middle, Mi			
Thomas R M		105 MAIL IN	G ADDRESS (Street		Route Number, City o			
Mr. Tony Bru					e., Pri			e. Md.
20e. METHOD OF DISPOSITION 1 Pariet 2 Cremetion 3	Removal from State	20b. PLACE AND DATE	E OF DISPOSITION //	Varne of	DATE 20	c. LOCATION —	City or Ton	vn, State
4 Donation 5 Other (Specify, 21. SIGNATURE OF FUNERAL SERVI		Wicomic	o Memori	Lal Park	2/27	SALISBL	JRY.	MARYLAND
	(: 1	моооо	Hir	ıman Fur	neral H			
23. PARY I. Entar the diseases	, or complications that of	aused the death. Do	not antar tha m	Oda of dying, au	Anne. Mo	applicatory an	reat,	Approximata
immediate Cause (Final disease or condition	ahock, or heart failure. List Dnly one cause on each line. Interval Between Onset and Death							
resulting in death)	a. ONGO	STOPE PLE R AS A CONSEQUENCE OF	2/4/21 OF):	Bilen	a			years
Sequentially list conditions.	- Hyg	salasion	f-0,1	Beles				yerors S
If any, leading to immediate cause. Enter UNDERLYING	DUE TO (O	R AS A CONSEQUENCE	OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (O	R AS A CONSEQUENCE	OF):					
Distriction of the control of the co	d							-
	ditiona contributing to de	eath but not reaulting	in the underlyl	ng cause givan in	Part I. 24a. WA	S AN AUTOPSY RFORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Apran	ceo Age				1 🖸 YE	S 2 NO		OF DEATH?
DID TOBACCO USE CO			ES 🖾 NO [UNCERTAL	N 🗆			t TYES 2 NO
DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN	HOSPITAL:		OTHER:					
27. MANNER OF DEATN	28e. DATE OF IN		ME OF 28c. IN	JURY AT	8 Other (Specify, 28d. DESCRIBE N		CURED	
t Natural 5 Pending 2 Accident Investiga	tion		M 1 🗆	YES 2 NO				
3 Pulatida	2 Pulatide							
	PNYSICIAN: To the best of my							end menner es stated
29b. SIGNATURE AND TITLE OF CEP				29c. LICENSE NU				(Month, Day, Year)
		10		037	813	•	2/2	7/95
	N WNO COMPLETED CAUSE	OF DEATH (ITEM 27) (Typ	e, Print)	Hurr	prine	SAL	- 112	D 2180(
FFR 2 8 1995	Jahr Managazand	CANDINAME						

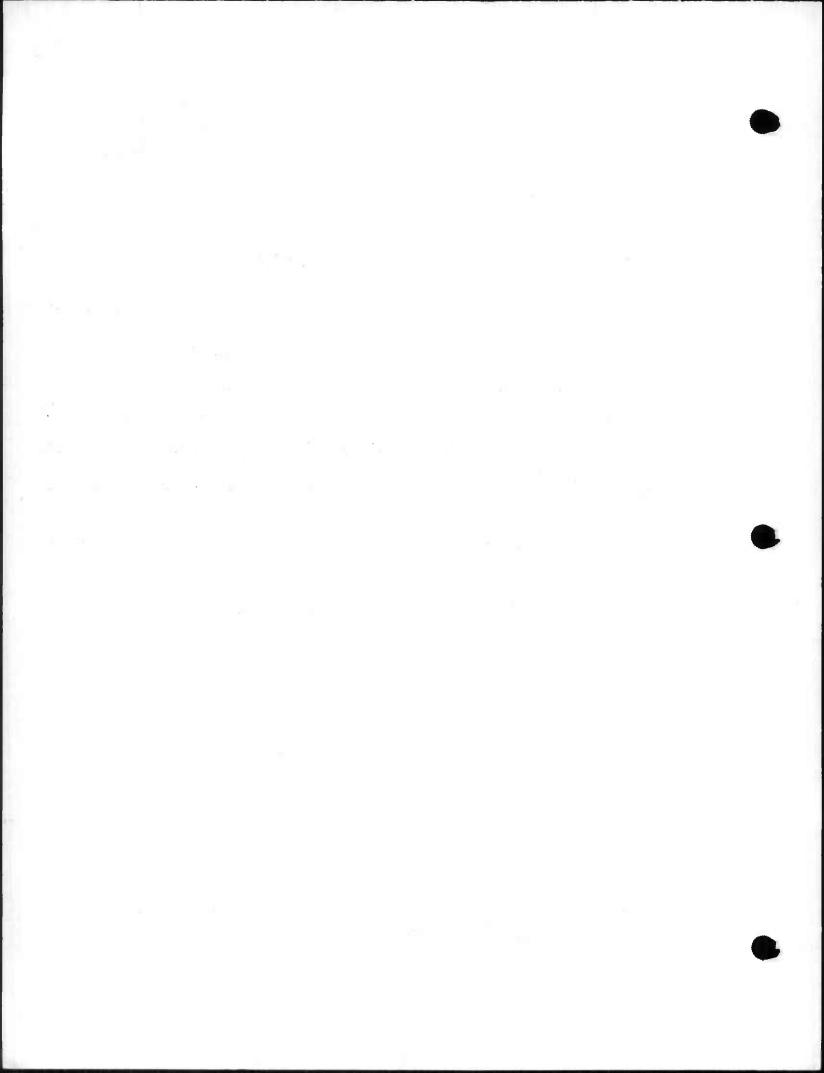
12 March 1 14 Apr 583.

BALTIMORE, MARYLAND 21215-0020	ficate be executed with. Ours after death. Page 6 may be retained by the hospital or attending physician.	physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
	101	filled
BOX 68760,	ficate be executed with	physician and completely

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

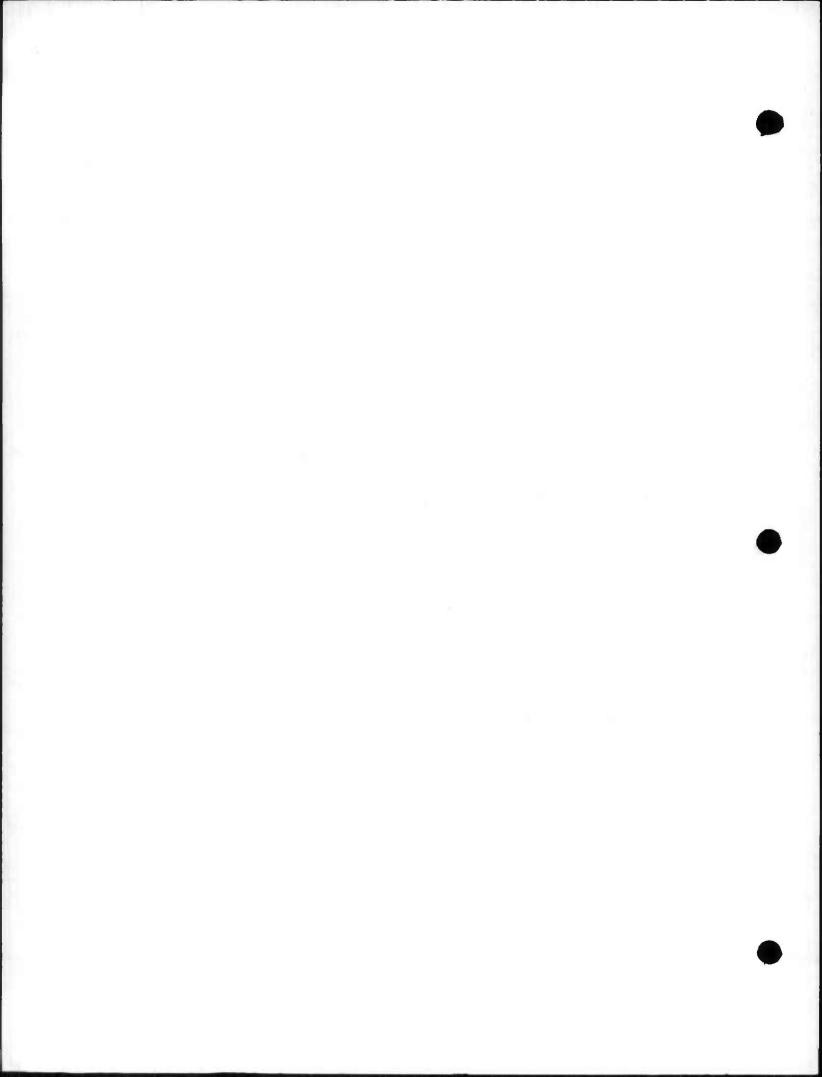
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ļ	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached hav use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENI REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA	YEAR 3. TIME OF OEA	тн
	Dottie Lawrence		yrs, last birthday)	JNDER 1 YEAR # UNDER 24 HRS.	February		
		100,710,000	6 YRS. MON		7. DATE OF BIRTH (Month, Day, Year) 3-25-1930	8 North Can	
	9a. FACILITY NAME (If not institution, give street			CITY, TOWN OR LOCATION OF O		9c. COUNTY OF OEATH	0207
10R	Deer's Head Cer	nter	s	alisbury		Wicomico	
DIRECTOR	10a. STATE 10b. COUNTY			WN OR LOCATION		10d. INSIDE CITY	Y
	Md. Wicon	mico	Sali	sbury		1 🖔 YES 2 🗌	NO
RA	100. STREET AND NUMBER 933 E. Church.	Street		101. ZIP CODE 2/80/	,	U.S.A.	
FUNERAL	11. MARITAL STATUS 12	WAS DECEDENT EVER IN I	U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yea	or No- 14, RACE - American Indi	lan,
BY F	1 Never Married 2 Married 3 Widowed 4 XDivorced	FORCES? 1 YES	ES MAO	If yes, specify Cuban, Mexic. 1 YES 2 NO Specific NO.		Black, White, atc. Specify:	,.
0	15. DECEOENT'S EDUCAT		16a. DECEDENT'S USU	AL OCCUPATION	16b. KIND OF BUS		dian
LET	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4 or 5 +)		done during most of working red.)			- 1
once.	17. FATHER'S NAME (First, Middle, Last)		Cook/Wa		Resta		
# III	Andrew H. E.	vans			cy E. Lyn		
O B	19a. INFORMANT'S NAME (Type/Print)			RESS (Street and Number or Rural	Route Number, City or Town	State Zip Code)	
be notified TO BE	Ivory L. Richard		933 E.			sbury, Md. 218	0/
must	1)© Burlal 2 Cremation 3 Removal	I from State 20b. F	PLACE AND DATE OF DI	sposition (Name of hapel Churc)	OATE 20c. LOC	ifaxCounty, N.	c.
line	21. SIGNATURE OF FUNERAL SERVICE LICENT	SEE /	01	22. NAME AND ADDRESS OF FA		- participation of the same of	
ехэш	seiald C	1 sour	108	Bounds Fund	enal Home	, Salisbury, Md	
medical examiner must	23. PART I. Enter the diseeses, or com shock, or heert fallure. Liet	nplicetione that caused to only one ceuse on ear	the death. Do not e	nter the mode of dying, aud	ch ea cerdiec or respir	atory arrest, Approxim	
the state of	iMMEDIATE CAUSE (Fine)	7.2.33	5			Onset sn	d Desth
event,	resulting in death) a	OUE TO (OR AS A C	OI THE	esophagus		5 ye	ears
	Sequentially list conditions, b						
traumatic ATION	If any, leeding to Immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF):				
other TIFIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF):				
P	resulting in deeth) LAST						
Injury,	PART il. Other aignificent conditiona c	ontributing to deeth but	t not recuiting in th	e underlying ceuse given in	Pert i. 24a. WAS AN / PERFORI		
T amy					1 TYES 3	COMPLETION OF	
shows						1 YES 2	NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PLACE OF DEATH (CI	neck only one)		
or Ite	1 TYES 2 THO	OSPITAL:		HER: Nursing Home 5 Rasidence	6 - Other (Specify)		
marked, or BY PHY	27. MANNER OF DEATH 1. Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c, INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED	
Is mar D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Specif)	At home, lerm, street			nd Number or Rural Route Number,	-
28 H	4 Homicide detarmined	building, att. (Specif)	"		City or Town, State)		
APL	anal .			the lime, data end place, and du			
CO	29b. SIGNATURE AND TITLE OF CERTIFIER	In the beete of examination (and/or Investigation, in			due to the cause(a) and menner as a	
MPORTANT:	, Mi	Here 1	40	29c. LICENSE NU D16003	MSER	29d. DATE SIGNED (Month, Day, Year)	<u></u>
2	30. NAME AND ADDRESS OF PERSON WHO C						-
	Inja Hwang c/o [Deer's Hea	d Center	P.O.Box 20	18 Salis.	Md. 21801	
	FEB 2 8 1995	37 DEGISTRAR'S SIGNAT	Kardall				



BOX 68760	
P.O.	
RECORDS,	
OF VITAL	
DIVISION	

		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTA	L HYGIENI REG. NO.	E		
	11	1. DECEDENT'S NAME (First, Middle, Last)	Lola	Mae Le	mon		2. DATE	OF DEATH		EAR 3.	TIME OF DEATH
		Lola M Lemon					0:				0650 M
	3			in yrs. lest birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Monti	OF BIRTH	6.	BIRTHPLA Country)	CE (State or Foreign
2	N.		□ M 2 😾 F	61 YAS.			04-	01 - 33		Mary:	land
shou	~	9a. FACILITY NAME (If not institution, give stree				OR LOCATION OF D	EATH		Bc. COUNTY	OF DEAT	Н
physician. burial-transit permit. Pages 1, 2, 3 should	DIRECTOR	Peninsula Region	nal Medica		Salis				Wico		
Pages	2	Manual and IT.		10c. CIT	Y, TOWN OR LOCA					100	1. INSIDE CITY LIMITS?
mit.	1.0	Maryland Wico	mico		Salisbu						YES 2 NO
it per	FUNERAL	323 Chestnut Way			10	2 180 1					COUNTRY?
ian. trans	N.		2. WAS DECEDENT EVER IN	III O ARMEO	40 1100 00					SA	
physician burial-tra		1 Never Married 2 Married	FORCES? 1 YES	2 XNO	If yes, sp	CENDENT OF HISPA pecify Cuban, Mexico	an, Puarto I		or No.— 14	Black, W	American Indian, hite, etc.
ging the	BY	3 K Widowed 4 Divorced	IF YES, GIVE WAR OR DA	AIES	1 [] YES	3 2 XNO Specif	fy:			Specify:	White
r attending use as the	8	15. DECEDENT'S EOUCAT (Specify only highest grade col	ION mo(otoci)	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b	. KIND OF BUS	INESS/INDUS		wille
5 2	<u> </u>		College (1-4 or 5+)	life. Do NOT us	vork done during m se retired.)	ost or working					
the hospital of detached for once.	M M	10		School	Bus Dri	ver	V	Vicomio	o Cou	nty	
the hospital detached fo	COMPLET	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, i	Middle, Maiden	Surname)		
3 E &	ш		ohnson			Helen		Ra	athel		
5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural					
5 5	-	Nancy Vollmer		2861	4 Ocean	Gateway	, Sal	lsibury	, MD	2 180	1
E 2 15		20a. METHOO OF DISPOSITION 1 X Burlel 2 Cremation 3 Flamove		PLACE AND DATE O			DAT		CATION — City	or Town,	Stata
Page 6 Il directo		4 Donation 5 Other (Specify)		etary, crematory or of pringhill			2/24	4 Heb	oron,	MD	
death. Pag funeral di i. examiner		21. SIGNATURE OF FUNERAL SURVICE LICEN	100,			loway Fu		l Home			
9 7		W/C/0	ller	n		Snow Hi			isbur	v. MI	21801
ed within the hours ompletely filled in the cremation, or re-	N		Hypertens	sch line.	rdiova				atory arrea		Approximate interval Between Onset and Death Years
th certificate be ending physician I Hygiene prior to or other traus	CERTIFICATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST		CONSEQUENCE OF							
We the	AL	PART II. Other significant conditions of	contributing to death b	ut not reaulting i	n the underlyln	g cause given in	Part I.	24e. WAS AN			RE AUTOPSY FINDINGS
SICIAN: The law requires that the certificate has been signed by a the State Dept. of Health and to or Item 23 shows any It.	MEDICA	Old cerebral p	parietal i	nfarct				PERFOR		CO OF	MABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
law re as bee Dept. c	ä	DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE OF	DEATH Y	YES NO					
V: The cate ha State D	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		26. P	LACE OF DEATH (Ch	heck only or	10)			
CIAN: ortifica	YSI	1 N YES 2 NO 1	☐ Inpetient 2 ☐ ER/Outp	atlant 3X DOA		ne 5 🗆 Residence	8 🗆 Othe	r (Specify)			
PHYSIC this ce with t	РНУ	27. MANNER OF DEATH 1 X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI INJ	URY W	JURY AT ORK?	28d. DES	SCRIBE HOW IN	JURY OCCUP	RED	
DING PHYS After this death with	BY	2 Accident Investigation				YES 2 NO					
TTENDI TOR: A after d	<u>a</u>	3 Suicide 8 Could not be 4 Homicide determined	28a, PLACE OF INJURY building, etc. (Spec	— At home, farm, s	street, factory, offic	De .	281, LOC City	ATION (Street a or Town, State)	nd Number or	Rural Route	Number,
TO THE HOSPITAL OR A TO THE FUNERAL DIRECT DE filed within 72 hours IMPORTANT: If Item	OMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:								ause(a) an	d manner as stated.
FUN With	0 1	29b. SIGNATURE AND TITLE OF CERTIFIER	-			29c. LICENSE NU	MBER		29d. DATE S	IGNED (Ma	nth, Day, Year)
MPO THE	BE	John 5	. O. eller	a.m.	D W E	D03599		Į		-21-	
FFA	5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATHVITEM 27) (Type,	Print)	1003539			02-	-21-	73
		John T. Bulkeley			e Bluf	f Road,	Sal	isbur	y, MI	21	801
		FEB 2 7 1995	32 AEGISTRAR'S SIGN.	x Rardall							



3. TIME OF DEATH

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8:14

Maryland

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

1 YES 2 NO

Approximate

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO

OF DEATH? 1 TES 2 NO

COMPLETION OF CAUSE

Interval Between

Onset and Death

7 mo

B. BIRTHPLACE (State or Foreign Country)

REG. NO.

1995

9c. COUNTY OF DEATH

Wicomico

10g. CITIZEN OF WNAT COUNTRY?

USA

Specify:

Morris

White

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND APOR

JOSED

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FEB 22 1995

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH WILLIAM **ASHER** JR. LYNCH February 17, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS MIN. 215-14-3259 1 M 2 - F YRS. December 11,1921 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 4272 Ramblin Rd. Salisbury RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Wicomico Salisbury permit. FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 21801 be detached for use as the burial-transit 4272 Ramblin Rd. Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuben, Mexican, Puerto Rican, etc.)
 To YES 2X NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced WW II COMPLETED 16a. DECEDENT'S USUAL OCCUPATION

(Calvan kind of work done during most of working 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Optomatrist Eye once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William at Asher Lynch Sr. Helen BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 4272 Ramblin Rd., Salisbury, MD 21801 Carolyn W. Lynch pe 20e. METHOD OF DISPOSITION
1 XBuriel 2 Cremation 3 F
4 Donation 5 Dether (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Springhill Memory Gardens 2/21 Hebron, MD examiner 22. NAME AND ADDRESS OF FACILITY
Holloway Funeral Home 21. SIGNATURE OF # WERAL SERVICE LICE hours after death. Pled in by the funeral of or removal. tot 501 Snow Hill Rd., Salisbury, MD 21801 medical 23/PART # Enter the diseases, or complications that cau the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart failure. List only one or filled IMMEDIATE CAUSE (Final completely filled rial, cremation, o the disesse or condition metastalle rostati. resulting in desth) traumatic event. DUE TO (OR AS A CONSEQUEN and com o burial, CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leading to immediate attending physician ntal Hygiene prior to 2 cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 signed by the attent Health and Mental H Injury. PART II. Other significant conditions contributing to death but not reculting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY shows any 1 TES 2 NO been of, of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) Item State certificate HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) the 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? this c marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO After t BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) DIRECTOR: A hours after d 3 Suicide 40 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 8 TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 H (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and placs, and due to the cause(s) and manner as stated.

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAR'S SIGNATURE

Jalia Davidson Rardall

145

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

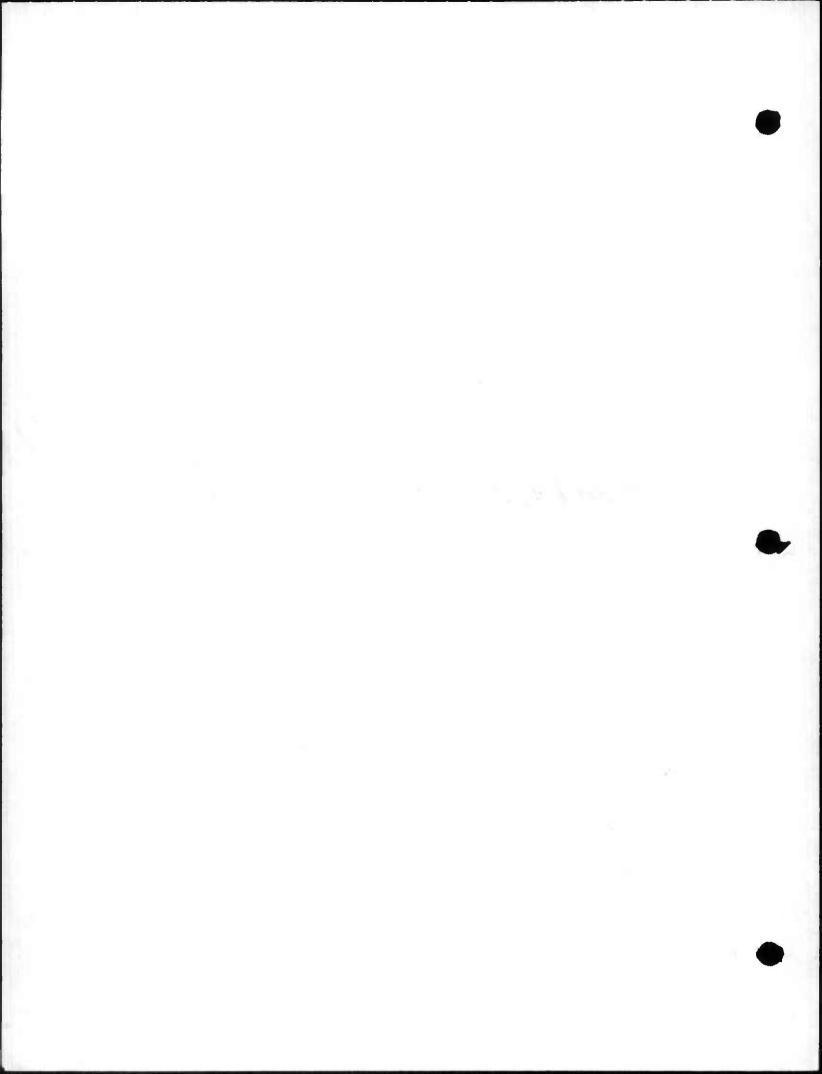
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29d. DATE SIGNED (Month, Day, Year)

29c. LICENSE NUMBER

CARROLL ST

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DIVISION OF VII AL RECORDS, P.O.	OSPITAL OR ATTENDING DAYSICIAN: The faw requires that the death certificate he executed within 2
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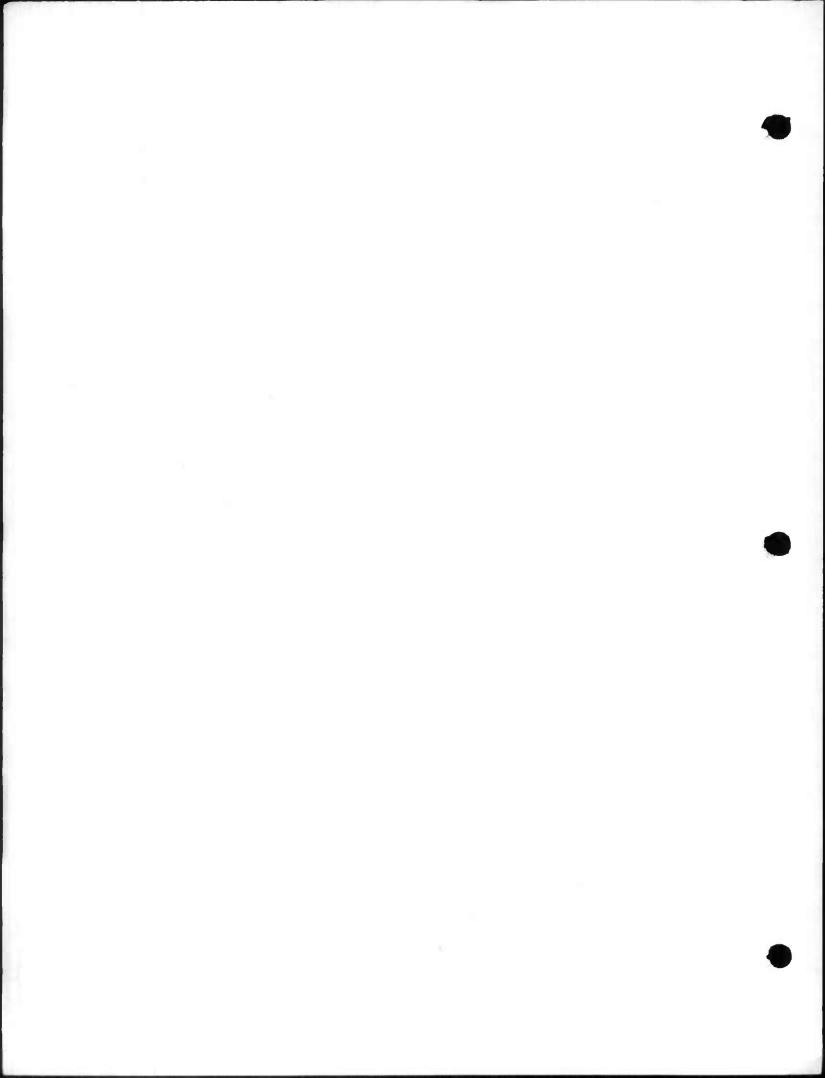
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Feb GLENDA J. LONG 6:00PM 995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Yea BIRTHPLACE (State or Foreign Country) 1 🗌 M 2 🕁 F DAYS HOURS YRS. 221-28-7920 76 FEB. 25 DELAWARE 1918 for use as the burial-transit permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and nur 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY DELAWARE SUSSEX SELBYVILLE 1 - YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 210 HOOISER STREET EXTENDED 19975 USA death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-JALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Ri 1 YES ZY NO BY Specify 3 ₩ Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) detached 12 POSTAL CLERK U.S. POSTAL SERVICE 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) page 5 should be notified at JOHN E. SEBOLD BE MARION NEWCOMB 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 JEROME LONG RT.2 BOX 226 G, SELBYVILLE, DELAWARE 19975 ě 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) director, REDMEN S CEMETERY 2/20/9\$SELBYVILLE, DELAWARE examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY the funeral HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 11 medicai 23. PART i. Enter the diseases, or complications that curred the det shock, or heert fallure. List only one cause on each line. med tha death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, filled in by 0 interval Batween ysician and completely filled prior to burial, cremation, or traumatic event, the m **IMMEDIATE CAUSE (Final** Onset and Death disease or condition obstructive pulmonary hronic resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, ending physician an I Hygiene prior to b DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the atten injury, PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS A Pue AMAILABLE PRIOR TO shows any signed l COMPLETION OF CAUSE 1 - YES 2 - NO OF DEATH? 1 YES 2 NO been t. of I PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Hem 26. PLACE OF DEATN (Check only one) certificate I OTHER: 1 YES 2 NO 1 2 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursi ng Home 5 Rasidence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY marked, 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED this with 1 Natural 5 Pending Investigation м 1 YES 2 NO After t 8 2 Accident 28a. PLACE OF INJURY — Al home, farm, street, factory, office building, stc. (Specify) 3 Sulcide .00 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be DIRECTOR: hours after 4 Homicide 28 datermined Hem COMPL 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. THE HOSPITAL OF THE FUNERAL DE TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated, 296. SIGNATURE AND TITLE OF CENTIFIER. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, N 0 30. MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) tric a hone

32 AEGISTRAR'S SIGNATURE Jahra Davidson Randall

31, DATE FILED-MA

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1995



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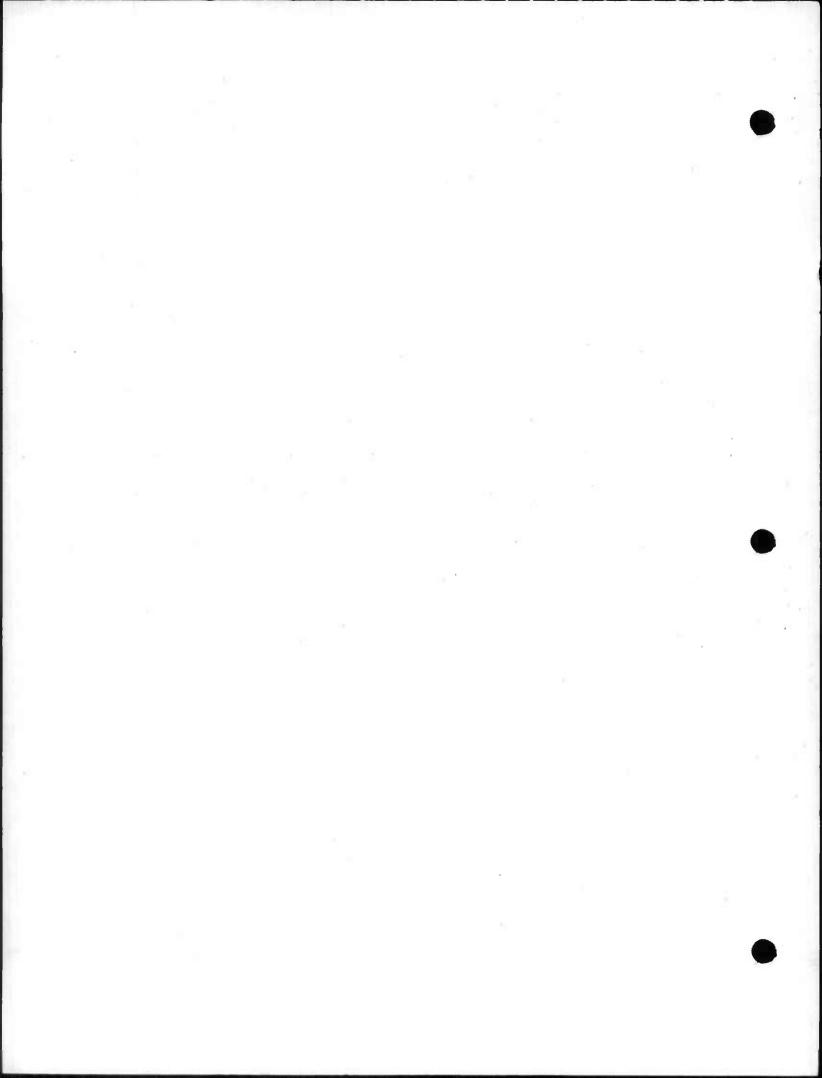
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Nancy Marie Lewis 3. TIME OF DEATH 16.95 February Nancy Lewis 6:50 O 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS HOURS 1 M 2 XF 77 213-12-5798 October 2. Maryland 1917 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Deer'S Head Center Salisbury Wicomico RESIDENCE OF DECEDENT 10h COUNTS 10e STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Wicomico Ouantico 1 YES 2 X NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 25994 Nanticoke Rd. use as the burial-transit 21856 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, sic. 1 Never Merried 2 Married 1 YES 2X NO Specify: Specify BY 3 🔯 Widowed 4 🗌 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only his Elementary/Secondary (0-12) funeral director, page 5 should be detached for College (1-4 or 5+) 10 Homemaker once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ŧ John Gillis Nellie Fitzgerald BE notified 15a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Rosalie Robertson 6682 Quercus Dr., Hebron, MD 21830 pe 20n. METHOD OF DISPOSITION 1 X Buriel 2 ☐ Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Must 4 Donation 5 Other (Specify) Mardela Memorial Cemetery 2/19 Mardela Springs, MD 21. SIGNATURE OF PUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 and completely filled in by the burial, cremation, or removal the medical 23. PART I. Enter the diseases, or complications that outside the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximate Interval Between 0 IMMEDIATE CAUSE (Finel Onsat and Death disease or condition resulting in death) Colon cancer with metastasis to bones, lungs, 2 years event, DUE TO (OR AS A CONSEQUENCE OF) and brain. traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 If any, leading to immediate cause. Enter UNDERLYING attending physician ital Hygiene prior to CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the atten Mental PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TYES 2 XNO 23 shows 1 YES 2 NO t, of h PHYSICIAN: certificate has be n the State Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO ↑ Inpatiant 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 鲁 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED this marked, 1 Natural 5 Pending Investigation 1 YES 2 NO B death After 2 Accident DIRECTOR: After hours after deal item 28 is m 28a. PLACE OF INJURY — Al home, farm, streel, factory, offica building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29s. CERTIFIER (Check only one)

29 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL I = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29¢ LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 9 Thy M.D D16003 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSS OF DEATH (ITEM 27) (Type, Print) Inja Hwang, M.D.
31. DATE FILED (Month, Day, Year)
FEB 21 1995 /o Deer's Head Center P.O.Box 2018 Salis.

32. REGISTRAN'S SIGNATURED

21803

Ma



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF	DEATH	RE	G. NO.		
		RLAMOND		LE	MPKE	2. DATE OF DI EBRUA	RY27,	1955	3. TIME OF DEATH 11:30P
	214-46-6629	□ M 2XXF 47		UNDER 1 YEAR NTHS DAYS	HOURS MIN.	7. DATE OF BII (Month, Day, April	Year)	Count	HPLACE (State or Foreign try) Shington, D.C
TOR	9e. FACILITY NAME (If not institution, give street 122 STODDERT AV RESIDENCE OF DECEDENT			ALDO	OR LOCATION OF DI		9c. C	ARLES	DEATH
DIRECTOR	10s. STATE 10s. COUNTY Maryland Charl	.es	10c. CITY, T Wald				10d, INSIDE CITY LIMITS? 1 YES 2 XNO		
FUNERAL	100. STREET AND NUMBER 122 Stoddert Aven			1	01. ZIP CODE 20602		10g. (USA	WHAT COUNTRY?
B	11. MARITAL STATUS 1 XXever Married 2 Married 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER II FORCES? 1 1 YES IF YES, GIVE WAR OR D.	2XXNO	13. WAS DE If you, a 1 _ YE	CENDENT OF HISPAI pecify Cuban, Maxica S 244 NO Specif	NC ORIGIN? (Spe in, Puerto Ricen, y:	cify Yes or No- etc.)	14. RACI Blaci Spec	E — American Indian, k, White, atc. White
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) 2	CON npleted) College (1-4 or 5+)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re Paralega	done during n tired.)	ION lost of working		J.S. G	I MARKET CO.	ment
	17. FATHER'S NAME (First, Middle, Lest) Edward Wil	liam I	Lempke		16. MOTHER'S NA	ME (First, Middle,		e)	Grammar
TO BE	190. INFORMANT'S NAME (Type/Print) Edward William		19b. MAILING AD		and Number or Rural	Route Number, City	y or Town, State,	Zip Code)	STUMBLE
	20a. METHOD OF DISPOSITION 1 Burtal 2X Cremation 3 Removal	201	PLACE AND DATE OF D	ISPOSITION //	Avenue Verneed	DATE	20c LOCATION	- City or To	own, State
	4 Donation 5 Other (Specify)	SEE A	Petery, cremetory or other Huntt Crem	22. NAME /	NO ADDRESS OF FA	CILITY			yland
	Shirley Capoka	letti M0084		P.O.E	Huntt Fun Box 156 W	aldorf.	MD 20	604-0	156
	23. PART i. Enter the diseases, or com- shock, or heart fellure. Lief iMMEDIATE CAUSE (Finel disease or condition	nplications that couse to only one cause on a	the deeth. Do not ech line.	enter the m	ode of dying, suc	h as cerdiec o	r respiratory	erreet,	Approximate Interval Between Onset and Death
_	resulting in deeth) e		CONSEQUENCE OF):						13413
CATION	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in desth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
DICAL C	PART II. Other eignificent conditions of		ut not recuiting in t	he underlyl	ng ceuse given in	- 1	WAS AN AUTOPS PERFORMED? YES 2 0		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
2	HYPERTENSIC		E DEATH VEC		d uniceptan	_	3/		OF DEATH? 1 YES 2 NO
PHYSICIAN:			26. PLACE OF DEATH (<u>и П</u>			
HYSI	1 VES 2 AVO 1 (27. MANNER OF DEATH	Inpatiant 2 ER/Outp 26a. DATE OF INJURY (Month, Day, Year)		Nursing Ho	me 5 Realdence	6 Other (Spec		OCCURED	
B	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY	At home, farm, stree	M 1 🗆	YES 2 ND	26t. LOCATION	(Street and Num	ther or Rural i	Route Number
ETE	4 Homicide daterminad	building, etc. (Spec	eny)			City or Town	n, State)		
COMPLETED	(Check only CERTIFYING PHYSICIAN	N: To the best of my know On the basis of examples							s) and manner as stated,
H H	296. MONITURE AND TITLE OF CERTIFIER!	Repris	mo		29c. LICENSE NUR	419	29d. C	ATE SIGNED	(Month, Gay, Year) 28/95
2	TO NAME AND ADDRESS OF PERSON WHO CO	RD, MD. 700			TER SIIT	TE 100	WAID	OPF	20602 MARYLAND
	31. DATE FILED (Month, Day, Year) MAR 0 2 1995	32. REGISTRAR'S SIGN	ATURE	32,11	-21 001	100	ייארו	URT.	HARILAND

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE RUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

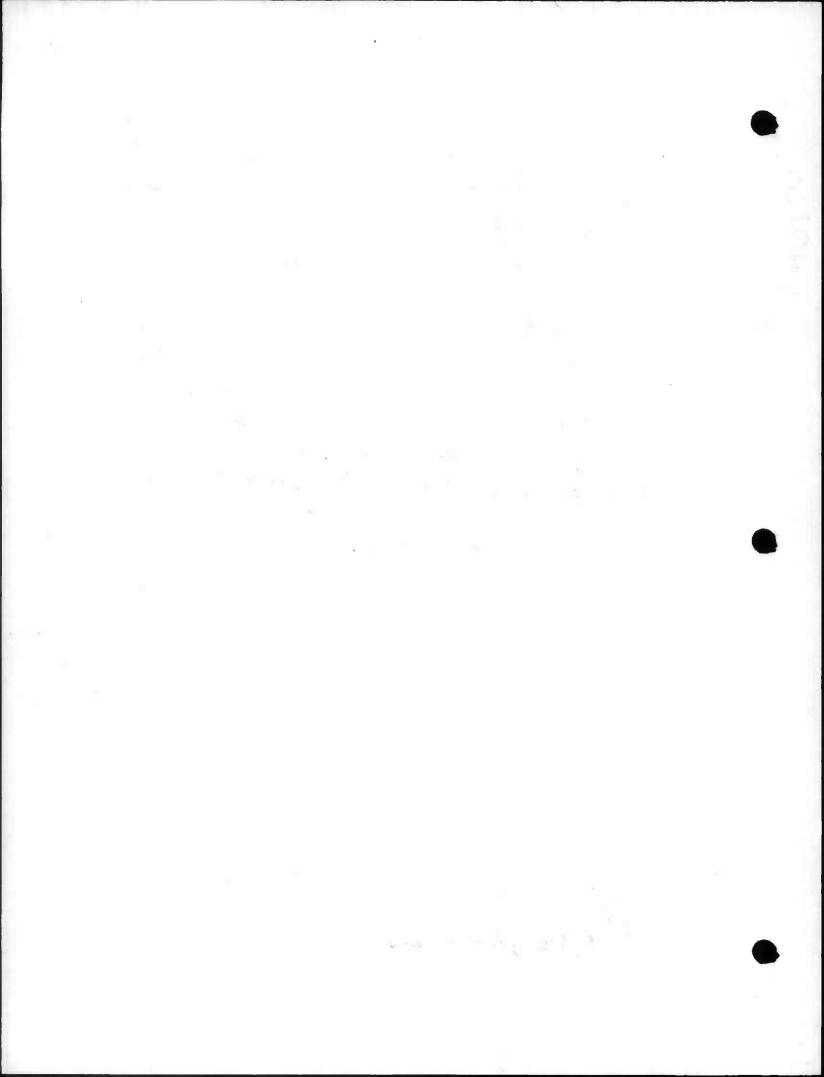
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF I				3. TIME OF DEATH	
	HAZEL I				LIBBY	7			MONTH 02	25	1	YEAR 95	12:55 B	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER		IF UNDER	24 HRS.	7. DATE OF B	WRTH		6. BIRTHE	PLACE (State or Foreign	
	219-12-8613	1 🗆 M 2 💢 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	OCT .	y. Year) 20 , 1	907	Country	YLAND	
	9e. FACILITY NAME (If not Institution, give st	reet and number)			9b. CITY	, TOWN	DR LOCATION			20,1		NTY OF DE		
۳۱	WILLIAM HILL HE	EALTH C	ARE			EA	STON				т	ALBO	·m	
DIRECTOR	RESIDENCE OF DECEDENT													
	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION												10d. INSIDE CITY LIMITS?	
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF V 21617 11. MARIITAL STATUS 1 Never Merried 2 Merried 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC DRIGIN? (Specify Yee or No— 14. RACI Black 14. Pace 15. Was Decembent of Hispanic Drigin? (Specify Yee or No— 15. Black 15. Was Decembent of Hispanic Drigin? (Specify Yee or No— 16. Black 16. ZIP CODE 10g. CITIZEN OF V 11. WAS DECEMBENT OF HISPANIC DRIGIN? (Specify Yee or No— 16. Black 16. ZIP CODE 16. ZIP												1 XVES 2 ND		
									10g. CITI	ZEN OF WI	HAT COUNTRY?			
										US	USA			
									14. RACE Black.	ACE — American Indian, lack, White, etc.				
									Specify.					

ETE	(Specify only highest grade	completed)		(Give kind of life. Do NOT u	work done (during n	nost of working	g	IOU. KIN	D DF BUS	INESS/INL	103 INT		
2	Elementary/Secondary (0-12)	College (1-4 or 5 -		MEMA	KER				- - (OWN	ном	Е		
COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, Middle					
S	GEORGE J. DORN	IER						AU	GUSTA	PIP	PIG			
m	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	S (Street	and Number	or Rural I	Route Number, C	ilty or Town	, Stete, Zip	Code)		
임	PETER F. LIBBY	Z		327	LAUI	REL	ST.	, E.	ASTON	. MI	21	601		
l	20e. METHOD OF DISPOSITION 1		20b. PLAC	E AND DATE	OF DISPOS	ITION //	Name of		DATE			City or Tow	rn, State	
	4 Donation 5 Other (Specify)	Wall Irom State	SAL	LSBUR	Y CI	REM	ATOR	Y	2-27	SAL	ISB	URY,	MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	权		22. NI	NAME /	AND ADDRE	SS OF FA	CILITY RAL H	OME	D	7		
	> YY/. K. Wew	your"	0	FS					ISON				, MD	
	23. PART I. Enter the diseases, or c shock, or heart feliure. I	omplications the	csused the	deeth. Do									Approximate	
	IMMEDIATE CAUSE (Fine)	Liet Only One Cau	se on eech a	ine.									Onset and Death	
	disease or condition resulting in death)	Mu	Ital	, N	106	lona 10						10cm		
	rosulting in death)	DUE TO	(DR AS CON	SEQUENCE O	F):	, ,							1	
Z		N			_									
읩	Sequentially liet conditions, if sny, leading to immediate	DUE TO	(DR AS A CONS	SEOUENCE O	F):									
2	CAUSE (Disease or injury													
RTIFICATION	thet initieted events resulting in death) LAST	DUE TO	(DR AS A CONS	SEDUENCE O	F):									
E CE		1												
	PART II. Other significant conditions	contributing to	deeth but no	t resulting	in the un	nderlyl	ng ceuse (given in	Part i. 24e	. WAS AN			WERE AUTOPSY FINDINGS	
DICAL									1.	PERFORI	/		AVAILABLE PRIOR TO COMPLETION DF CAUSE	
<u> </u>									'``		Cprio	- 1	OF DEATH? 1 YES 2 ND	
ž									_					
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?						PLACE DF D	EATH (Ch	eck only one)					
<u>s</u>	1 YES 2 DIO	HOSPITAL:	ER/Outpatient	3 DOA	OTHER 4 Nun		me 5 🗆 Re	aldence	8 Other (Sp	ecify)				
ᆵ	27. MANNER OF DEATH	28e. DATE OF (Month, D		28b. TIN	E OF JURY		JURY AT		28d. DESCRIE	BE HOW IN	JURY OC	CURED		
B	1 Natural 5 Pending 2 Accident Investigation				М		YES 2	ND						
ED	3 Suicide 8 Could not be	28e. PLACE O building,	F INJURY — At etc. (Specify)	home, ferm,	street, fact	tory, off	ice		28f. LOCATID	N (Street ei	nd Number	or Rural Ro	oute Number,	
	4 Homicide determined								, //	,				
COMPLET	290. CERTIFIER (Check only	CIAN: To the best of	my knowledge,	death occurr	ed at the t	ime, de	te end place	, end due	to the cause(e) end men	ner as atal	led.		
S	one) 2 MEDICAL EXAMINE	R: On the basis of e	remination end/	or investigation	on, in my o	pinion,	death occur	red at the	time, date end	place, end	due to th	e ceuse(e)	end manner ee stated.	
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	11 /	0				29c. LICI	ENSE NUI	MBER		29d. DAT	E SIGNED	(Month, Day, Year)	
0 8	William K	Thoul	1	MI			10	08	715			2/5	7/95	
F	36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAU	OF DEATH (TEM 27) (5)04	ASO.			~		_	A 1	1		
	WILLIAM K	WOOD	ント	14	レ			0=1	NORE	1	1/10	/ 7	160/	
	FEB 2 8 199	5 JULAN	A SHONATURE	Rardall										



DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

25. WAS CASE REFERRED TO MEDICAL

Investigation

8 Could not be

EXAMINER?

1 Natural

4 Homicide

27. MANNER OF DEATH

Accident 3 Suicide

1 YES 2 NO

	1. 2.	
	ift. Pages	
or attending physician.	R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, er death with the State Debt, of Health and Mental Hyplene prior to burial, cremation, or removal.	
ITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ge 5 should be detached	
after death. Page 6 may	by the funeral director, pa moval.	ingl avaminas must b
xecuted within 24 hours	and completely filled in burial, cremation, or re	natic event the mad
e death certificate be e	he attending physician i Mental Hyglene prior to	miner trainer frame
he law requires that th	e has been signed by the Dept. of Health and	m 22 chowe any in
TENDING PHYSICIAN: 1	TOR: After this certificat after death with the Stat	28 is marked or its.
THE HOSPITAL DR AL	THE FUNERAL DIRECT FILE MITHER THE THE THE THE THE THE THE THE THE THE	IPORTANT If item
2	2 3	1

95 07900 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle Leat) 2. DATE OF DEATH 3. TIME OF GEATH YEAR LOUIF VAN NAME LEF 1995 February 10:45 AM 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 X XF 219- 42-3547 85 May 13, 1909 Texas 9e. FACILITY NAME (If not institution, give street end number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH Carriage Hill Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Chevy Chase 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5330 Baltimore Avenue 20815 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Merried 1 YES 2 NO Specify: 3 Widowed 4 Divorced Specify: White 15. OECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Louis Carlton Van Name Ella May Fishback 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey P. Long 6900 Wisconsin Ave. #505 Chevy Chase, MD 20815 20e. METHOD OF DISPOSITION
1 Surfel 2 Cremetion 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Arlington National Cemetery 3-2 4 Donation 5 Other (Specify) Arlington , VA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P.A. alkille 933 Gist Ave. Silver Spring, MD 23. PART /. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiec or respiratory errest, Approximate shock, or haert fallure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death ·Un & disease or condition resulting in death) 18m DUE TO (OR AS A CONSEQUENCE OF ard Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. DATE OF INJURY

26. PLACE OF DEATH (Check only one)

М

OTHER: 4 Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify)

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify)

143496

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

Rockville, MD 20852

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner ee stated.

28b. TIME OF INJURY

2 MEDICAL EXAMINER: On the beele of axamination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end manner se stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO C PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HOSPITAL

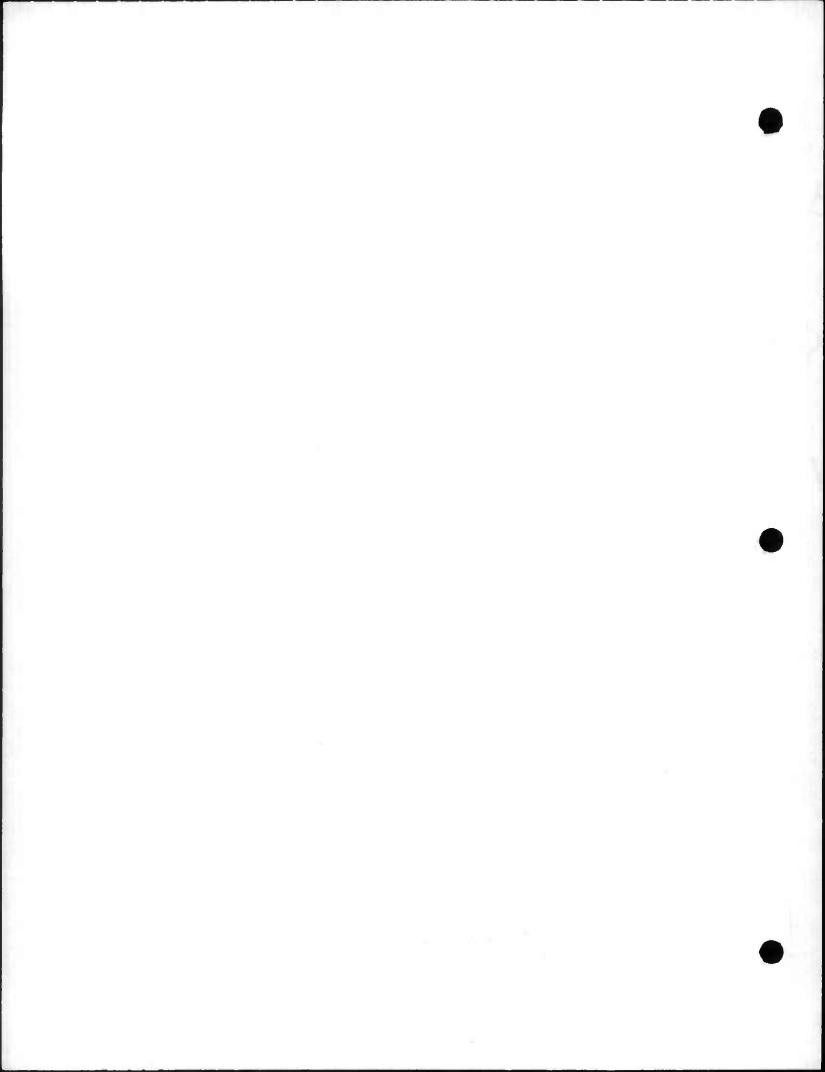
MOHAMMAD A. KHALID M.O. 4701 Randolph Road

31. DATE FILED (Month, Day, Year) 28 1995

22. REGISTRAR'S SIGNATURE

DHMH-16 Ray 1/89

1 YES 2 NO



	A	mended #	STATE OF MAR	YLAND / DEPA	MRT RTMENT OF	HEALTH AND	On to	HYGIENE REG. NO.	7 00	Paronty
_		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE C		3.	TIME OF DEATH
		K-Dren Kar	had air	rea-	100	met.	MONTH	DAY	YEAR	4:15 0 4
		4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH 1937	4 BIRTHPL	ACE (State or Foreign
		273-34-0682	1 🗆 M 2 🖵 F	57 YRS.	MONTHS DAYS	HOURS MIN.	(Month,		Country)	and forms or 1 or seller
3 should		9s. FACILITY NAME (If not institution, give st	reet and number)	31	9b, CITY, TOWN	OR LOCATION OF			Ohio	M
1, 2, 3 st	DIRECTOR	4008 Isbell Stree	t			aton			ontgo	
See	M I	10s. STATE 10b. COUNTY		10c. CF	TY, TOWN OR LOC	ATION			10	d. INSIDE CITY
£.	ā	Maryland Mo	ntgomery	ł	Wheaton				1.	LIMITS? YES 2 NO
E E	A	10e. STREET AND NUMBER				OI. ZIP CODE		10g. CITIZ	ZEN OF WHA	T COUNTRY?
nsit.	E	4008 Isbell Stree	t			20906		П.	S.A.	
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2.	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 🔞 Divorced	12. WAS DECEDENT EVE FORCES? 1 YOUR STREET YES, GIVE WAR OF	ES 2 NO	If yes, s		can, Puerto Ri	(Specify Yes or No-	14. RACE	American Indian, hite, atc.
as th	ED	III-2 A		la constant					Whi	te
MARYLAND 21215 retained by the hospital or attend 5 should be detached for use as notified at once.	1	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S	S USUAL OCCUPAT work done during n use retired.)	ION lost of working	16b. I	KIND OF BUSINESS/IND	USTRY	
D 2 pital	F	Elementary/Secondary (0-12)	College (1-4 or 5+)							
MARYLAND retained by the hospit 5 should be detached notified at once.	COMPLET	17. FATHER'S NAME (First, Middle, Lest)	4	Instruc	cional A	ssistant		ducation ddle, Melden Surname)		
at o be	C	Hilton K. Hauens	toin			0.000				
MAR retained 5 should notified	0	19a. INFORMANT'S NAME (Type/Print)	rem	19b. MAILING	D ADDRESS (Street			Carlson r, City or Town, State, Zip	Codel	
	2	Beth A. Lauriat						nantown, Ma		1 2087/
AE, lay be page	ì	20a, METHOD OF DISPOSITION		20b. PLACE AND DATE			DATE	20c. LOCATION — (
ORE 6 may ector, pa		1 Burial 2 Cremation 3 Remo	val from State	cemetary, crematory or netropolit	other place)		1	Alexandr		
Page a direction		21. SIGNATURE OF FUNERAL SERVICE LIC		ac opolic				Funeral H		
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		· Christophen	Maske	lun	500 U	niversit	y Blvd	1.,W. Sil.	Spr.,l	
5 2 5 5		23. PART I. Enter the diseases, or cahock, or heart feliure. I	omplications that ceu- liet only one ceuse or	sed the death. Do n eech line.	not enter the m	ode of dying, au	ich aa cerdie	ac or reapiratory arm	eat,	Approximate Interval Between
		IMMEDIATE CAUSE (Finel disease or condition	2 .5		2	1.1	4			Onset and Death
들 출 를 그		resulting in death)	Over	enosc	(and to	e He	ant	Desa	0	
P 0 10 10			OUE TO (OR A	AS A CONSEQUENCE O	OF):					
OX 687 e be executed sician and con ritor to burial, traumatic e	S I	Sequentielly list conditions,	Due To con a	S A CONSEQUENCE O						
BOX ate be en hysician a prior to	ERTIFICATION	if any, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR A	IS A CONSEQUENCE C	rr):					
e phy	윤	CAUSE (Disease or Injury that initiated events	DUE TO (OR A	S A CONSEQUENCE O	PF):					
P.O. ath certification at Hygies or oth	E	resulting in death) LAST								
	8									
RECORDS, requires that the desen signed by the at of Health and Ment shows any injury.	AL	PART II. Other eignificent conditions	contributing to deet	h but not reaulting	in the underlying	ng cause given i	n Part I.	24a. WAS AN AUTOPSY PERFORMED?		RE AUTOPSY FINDINGS
Signed the Health an Inws any	MEDICAL	And Bros	tersee					1 TES 2 NO	co	MPLETION OF CAUSE DEATH?
REC requires seen sign. of Heal	<u>u</u>	1,								YES 2 NO
- F O F -		DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH Y	ES NO [UNCERTA	IN 🗆			
VITAL IAN: The la tificate has e State Dep or item 23	S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA)				
F VIT/ SICIAN: The certificate the State	PHYSICIAN:	YES 2 NO	1 Inpatient 2 ER/O	Outpatient 3 DOA	OTHER: 4 Nursing Ho	me 5 Residence	6 Other ('Specify)		
NG PHYSIC fter this ce eath with th marked,	ВУ РН	27. MANNER OF DEATH Netural 5 Pending Investigation	26a. DATE OF INJUR (Month, Day, Yea		JURY W	JURY AT ORK? YES 2 NO	28d. DESC	RIBE HOW INJURY OCC	URED	
ISIC TTENDI TTOR: A after dd	ETED E	3 Suicide 6 Could not be detarmined	28s. PLACE OF INJU building, stc. (S	JRY At home, larm, Specify)	streel, factory, offi	ca	261. LOCAT City or	TON (Street and Number (Town, State)	or Rural Route	Number,
RO BIR	٦	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my kn	nowledge death occur	ad at the time dat	a and place, and du	o to the series		,	
THE HOSPITAL THE FUNERAL filed within 72 i	COMPL		On the bests of examine							d menner as stated.
THE HI filed wi	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	10			29c. LICENSE NU	UMBER	29d. DATE	SIGNED (Mo	onth, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

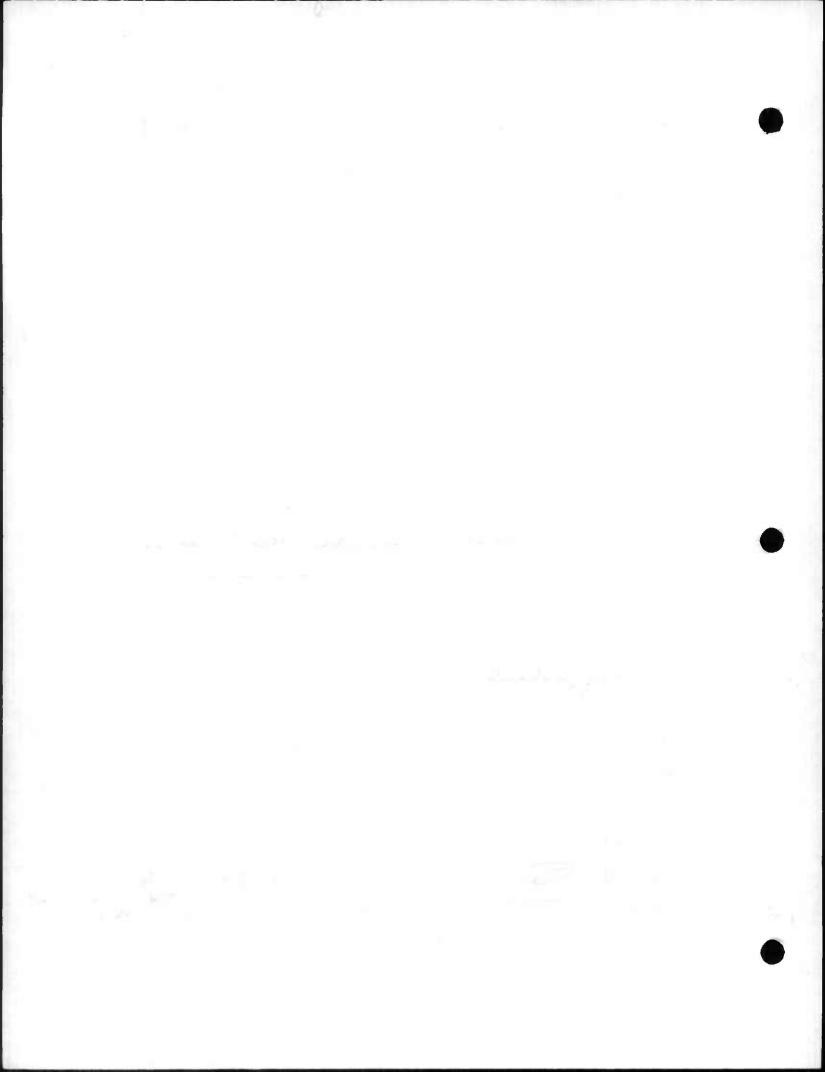
31. DATE FILEO (Month, Day, Year)

FEB 21 1995

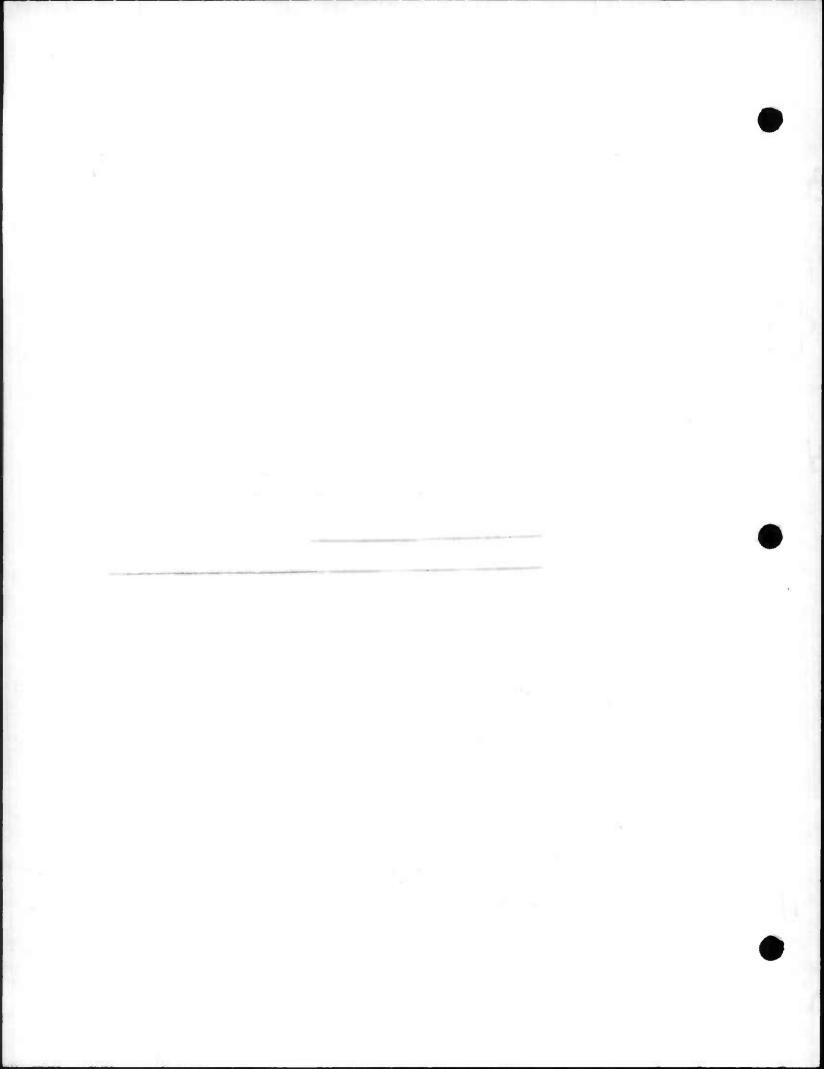
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(e) cs consco

DHMH-16 Rev 1/89



	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF	HEALTH AND DEATH	MENTAL	HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last, JANET	LIVIN				2. DATE O MONTH FEB.	27,1995	YEAR	3. TIME OF DEATH 10:05 AM M
TOR	4. SOCIAL SECURITY NUMBER 220–42–3145	1 🗆 M 2 🗶 F	yrs. lest birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, MARC)	е виятн Рау, Ува <i>г)</i> Н 18,1944	Country	PLACE (State or Foreign V) INSYLVANIA
	90. FACILITY NAME (If not institution, give HOLY CROSS HOSPI RESIDENCE OF DECEDENT			96. CITY, TOWN	TGOME				
DIRECTOR	10a. STATE 10b. COUN	MONTGOMERY		Y, TOWN OF LOCAL				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	1909 TREETOP LAN	E #11		10	20904		500		STATES
BY FUR	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, s	CENDENT OF HISPA pecify Cuben, Mexic S 2 A NO Speci	en, Puerto Ric	(Specify Yes or No— en, etc.)	14. RACE Black, Specify	— American Indien, , White, atc.
LETED	15. DECEDENT'S ED (Specify only highest grace (Specify only highest grace Elementery/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	18e. DECEDENT'S (Give kind of the life. Do NOT us	work done during m se retired.)	ION ost of working	16b. K	IND OF BUSINESS/II	NOUSTRY	
COMPLET	17. FATHER'S NAME (First, Middle, Last) DAVID ZALEZNIK		SECKET	AKI	18. MOTHER'S NA		MEDICAL Idle, Melden Surneme) T. S		
TO BE	190. INFORMANT'S NAME (Type/Print) HILDA REIBSTEIN				end Number or Rural	Route Number	City or Town, State, 2		,MD. 20852
10	28s METHOD OF DISPOSITION 1 & Buriel 2 Cremation 3 Real 4 Donation 8 Other (Specify)	MI MI	PLACE AND DATE (3/1	20c. LOCATION -		H. C. C. L.
1	21. SUPPLIFIED OF FUNERAL SERVICE L	CENSEE Stone	2	DANZA		DBERG	MEMORIAL -ROCKVIL		ELS, INC.
	23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ceuse on ee DUE 79 (OR AS A	ch line.	· Ner	ELECTR	COLYTE I	MBALANCE RITIS		Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A OLD CO. DUE TO (OR CO. DUE TO (OR CO. DUE TO (OR CO. DUE TO (OR CO. DUE TO (OR CO. DUE		·	Way a	ull,	dul	rsf	,
MEDICAL	PART II. Other significant condition S DID TOBACCO USE CONT	renca	Å			_ '	4s. WAS AN AUTOPS' PERFORMED? YES 2 NO	PERFORMED? AVAI	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	1	8. PLACE OF DEAT	H (Check only one))				
BY PHY	27. MANNER OF DEATH 1. Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	ne 5 Residence JURY AT DRK? YES 2 NO	_	RIBE HOW INJURY O	CCURED	
ED	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	28e. PLACE OF INJURY — At home, farm, street, 1ectory, office building, etc. (Specify)						oute Number,
COMPLET		ICIAN: To the best of my knowle							end menner ee stated.
TO BE COMP	290. SIGNATURE OF TIPE OF EBRIFFE	56	H/M	rh		9s. LICENSE NUMBER			(Month, Day, Year) 266 1995
	16. NAME AND ADDRESS OF PERSON W WHITEN E - 600	2H MD/330	TH (HEM 27) (Type.	Print) KEFIE	up Rn	who	PATON	M	D 20902
	MAR 01 1995	3. REGISTRAR'S SIGNA	Rardall						



ital or attending physician. I for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.
he funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
er death. Page 6 may be retained by the hospi	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi

											95	5 (7903
	FOR 1 - STATE	STATE OF M	ARYLAND /	DEPAR	TMEN	T OF I	EALTH	AND	MENTA	L HYGIEN	E		
	REGISTRAR		CI	ERIIF	ICAI	E OF	DEAT	ТН	,	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)								MONTI	OF DEATH	AY	YEAR	3. TIME OF DEATH
		epre							Feb	25	199		8:00 P M
			6. AGE (In yrs. les 84		MONTHS	DAYS	IF UNDER	24 HRS.	7. DATE (Month	OF BIRTH		6. BIRTH Country	PLACE (State or Foreign
	370 03 2122	1 M 2 TF	04	YRS.		-	HOUNG	Milio.	Nov.	17, Day, Year)	1910	Penr	isylvania
_	9a. FACILITY NAME (If not institution, give stre	eet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	EATH		9c. COU	NTY OF D	EATH
l G	14400 Homecrest Ro	ad, Apt.	40	Silver Spring							Mon	tgome	ery
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION									
<u>E</u>												10d. INSIDE CITY LIMITS?	
	Maryland Montgo	mery		51	iver	Spr						1	1 YES 2 NO
RA			4.0			10	f. ZIP CODE				117		HAT COUNTRY?
FUNERAL	14400 Homecrest Ro						209					USA	
FU	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED NO	13.	WAS DEC	ENDENT C	F HISPAN	VIC ORIGIN	? (Specify Yes	or No-	14. RACE Black	- American Indian, White, atc.
₽	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES				2 📉 NO			, , , , , , , , ,		Specif	
	15. DECEDENT'S EDUCA	TION	16. DE	CEDENT'S	HEHAL O	COMPATI	201		Line				White
E	(Specify only highest grade or	ompleted)	(G	ive kind of a	work done	during me	st of workin	g	16b.	KIND OF BUS	SINESS/IND	DUSTRY	
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	- 1	Book					-	Resta	uran	t	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			2001	теср		140 14071	15010 ALA	145 (5)-1 4				
	William Meyers								uche:	Aiddle, Meiden	Sumame)		
BE	19e. INFORMANT'S NAME (Type/Print)		100	- MARINO	ADDRES	0 (00				er, City or Tow			
2	Catherine M. Burch									, Mary			702
							_	Aue					
	20e METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remov 4 Donation 5 Other (Specify)	ral from State	cemetery, cre. Gate	matory or o	ther place)	SITION (NE	ime of			20c. LO			
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSFF	Gate	OI H	avei	i Cei	metei	- y	Z	8 511	ver S	prin	g, Maryland neral Home
	1,16	7/								re Ave		II ru	neral nome
	111).	14-			- 5	Silve	er Sp	ring	g, Ma	ryland	d 20	904	
	Silver Spring, Maryland 20904 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, ahock, or heart feliure. Liet only one cause on each line.												
Ш	IMMEDIATE CAUSE (Fine)							Interval Between Onset and Death					
	diseese or condition resulting in death)	Emphys	ema										40 Yrs.
	<u>.</u>	DUE TO (C	DUE TO (OR AS A CONSEQUENCE OF):										
z		Cigare	tte Smo	king									40 Yrs.
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	DUENCE O	ት) :								
5	CAUSE (Disease or Injury												
쁜	that initiated events	DUE TO (C	OR AS A CONSEC	DUENCE OF	7):								
	d.	<u> </u>											
2	PART ii. Other aignificent conditions	contributing to d	eeth but not n	esuitina	n the ur	nderivin	Ceuse C	liven in	Part i	24a. WAS AN	AITTOREY	246	WERE AUTOPSY FINDINGS
MEDICA							9 00000 2			PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE
									— I	1 YES 2	™ NO		DF DEATH?
	DID TODACCO LICE CONTROL	DUITE TO CALL	CC OF DEA		- FVI	=							1 TES 2 NO
AN	DID TOBACCO USE CONTRI	BUIE TO CAU					UNC	ERTAIN	1 1				
PHYSICIAN:	EXAMINER?	HOSPITAL:		E OF DEAT	OTHE	R:	_		_				
IYS	1 VES 2 NO 1	I npetient 2 1					e 5 ⊠ Re	eldence	_				
	1 🖾 Natural 5 🗌 Pending	28e. DATE OF III (Month, Day		26b. TIM INJ	URY		BK?		26d. DE\$	CRIBE HOW II	NJURY OC	CURED	
B	2 Accident Investigation	24- 21 405 05	101 101 1001				/ES 2 [NO					
0	3 Suicide 6 Could not be 4 Homicide determined	building, et	INJURY — At hor ic. (Specify)	me, farm, s	dreet, taci	tory, office	•		28t, LOCA City o	ATION (Street e or Town, State)	and Number	or Rural Ro	oute Number,
直													
COMPLET	(Check only												
Ö	2 MEDICAL EXAMINER:	On the besie of exa	mination end/or i	nvestigatio	n, In my c	opinion, d	eath occur	ed at the	time, date	end place, en	d due to th	e cause(s)	and manner ee stated.
ш	350 SEMUTURE AND THEE OF BERTIFIER						29c. LICE	NSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
0 8	Many My						50	148	301	+ 1	P 2	2/27	195

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

9801 Georgia Avenue, Silver Spring, Maryland

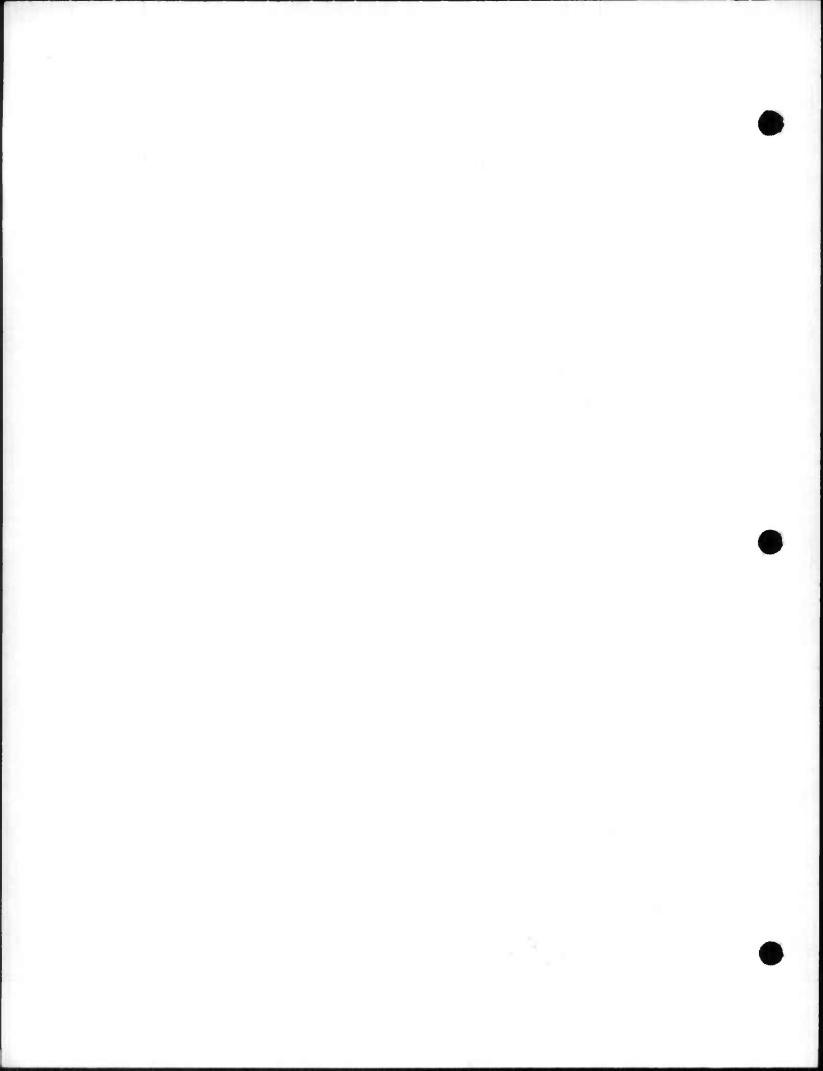
32. REGISTRAR'S SIGNATURE

Sub-live Reveal.

Mark Eig, M.D.

31. DATE FILED (Month, Day, Vour)
MAR 03 1995

DHMH-16 Rev 1/89



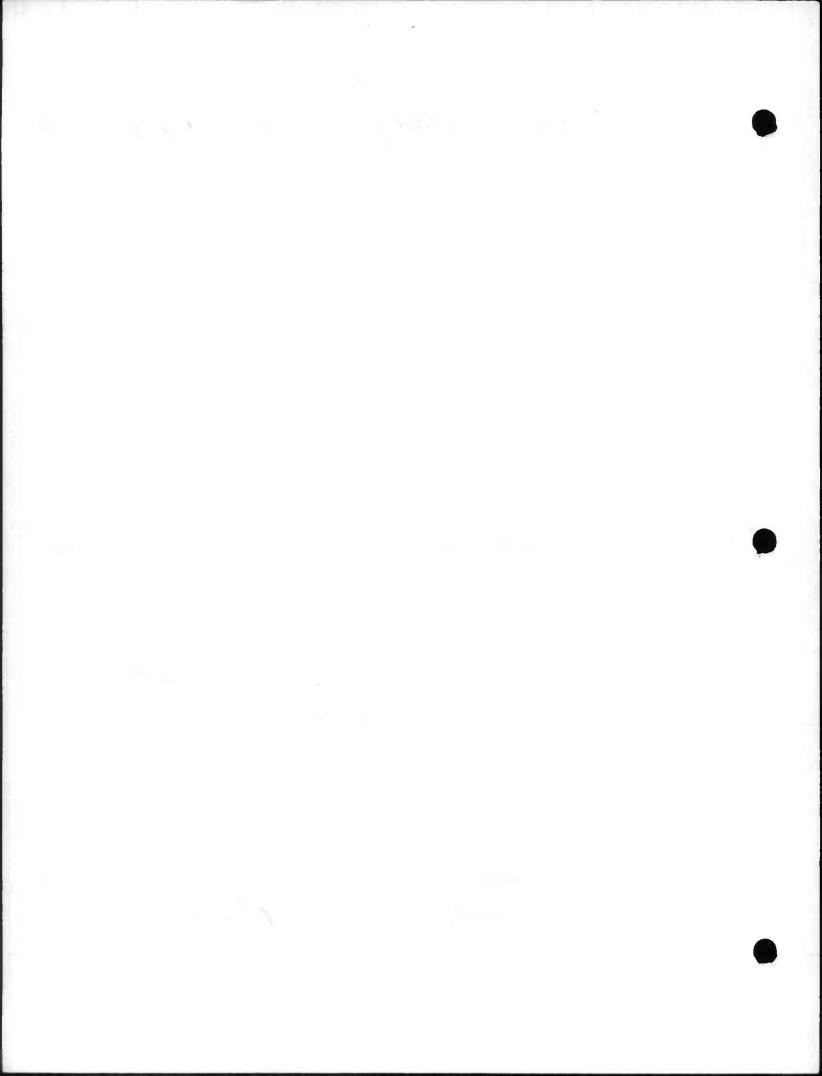
|--|

SUGUSTO

31. DATE FILED (Month, Day, Year)
MAR 0 6 1995

32. REGISTRAR'S SIGNATURE

7.3	1. DECEDENT'S NAME (First, Middle, Last)	Charl	es Al	tin Lov	ring, Sr.	PATE OF DEATH	MAY	3. TIME OF DEATH				
8	4. SOCIAL SECURITY NUMBER			VING		March 1	119	95 1100/				
	228-30-3913	1 📉 M 2 🗆 F	AGE (In yrs. les	YRS. MONTHS	ER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	April 28	3/30	/B. BIRTHPLACE (Stetle or Fore Country) VA				
LOR	90. FACILITY NAME (If not institution, give street and number) So. Maryland Hospital RESIDENCE OF DECEDENT 90. CITY, TOWN OR LOCATION OF DEATH Clinton 9c. COUNTY OF DEA Prince G											
DIRECTOR	100. STATE 10b. COUNTY MD Char			Waldo:				10d. INSIDE CITY LIMITS? 1 YES 2 X N				
FUNERAL	100. STREET AND NUMBER 109 Brookside	Place			101. ZIP CODE 20601			S.A.				
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 TO IF YES, GIVE WITH 2/19/51	YES 2 TH	13 13 13 15 15 15 15 15 15 15 15 15 15 15 15 15	WAS DECENDENT OF HISP If yes, specify Cuban, Mexi- 1 YES 2 NO Specify	cen, Puerto Rican, atc.)		14. RACE — American Indian Black, White, etc. Specify: White				
ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S USUAL	OCCUPATION a during most of working	16b. KIND OF BU	SINESS/IND	USTRY				
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life.	ore Mai)	- 1 - 5	Foo	of Store				
BE CON	17. FATHER'S NAME (First, Middle, Last) John Lee Lovin	g			18. MOTHER'S Myrtl	e Beasley	Sumame) 7 LOV	ring				
TO B	190. INFORMANT'S NAME (Type/Print) Lottie Loving		3	310 Di	ss (Street and Number or Rure ana Lee Cr	t. Va. Be	each,	Va. 23452				
	20e. METHOD OF DISPOSITION 1	oval from Stale		AND DATE OF DISPO	osition(Name of n) Crem, 3/	4/95 Ale		City or Town, State				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENDER	TIC CI C	POILCA	II OTCIII, J/	サルフラ トバエリ	Mail					
	Adamid C	Elal	M009	1/15 A	REHART-ECH	OLS FUNE	RAL H	HOME, INC.				
	23. PART I. Enter the diseases, or c shock, pr heert failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Echal complications that c List only one cause	eused the de on each line	945 P eath. Do not enta	REHART-ECH	OLS FUNES LaPlata	RAL H	HOME, INC. 20646				
IFICATION	shock, or heert failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	Elist complications that could be complicated as the course of the cours	eused the de on each line	eath. Do not ental. OUENCE OF):	REHART-ECH	OLS FUNES LaPlata	RAL H	HOME, INC. 20646 est, Approximet				
ERTIFICATION	shock, or heert failura. I	Elist complications that could be complicated as the course of the cours	eused the de on each lina 3 21 R AS A CONSEC	eath. Do not ental. OUENCE OF):	REHART-ECH	OLS FUNES LaPlata	RAL H	HOME, INC. 20646 est, Approximet				
MEDICAL CERTIFICATION	shock, or heert failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OF	eused the de on each line J 21 R AS A CONSEC	Peath. Do not entail. OUENCE OF): OUENCE OF):	REHART-ECH .O. Box 56 ar the mode of dying, su	FACILITY IOLS FUNEI TO LaPlata Ich ae cerdlec or resp	RAL H	HOME, INC. 20646 est, Approximet				
MEDICAL	shock, or heert failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions	DUE TO (OF DUE TO (OF	eused the de on each line J 21 R AS A CONSEC R AS A CONSEC R AS A CONSEC eth but not r	Peath. Do not entail. OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF):	REHART - ECH. O. Box 56 In the mode of dying, su Inderlying ceuse given in 28. PLACE OF DEATH (6)	n Part I. 24a. WASAN PERFO	RAL H	Approximet Interval Bet Onset and On				
MEDICAL	shock, or heert failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions DID TOBACCO USE Caramyer? 1 VES 2 NO	DUE TO (OF DUE TO TO TO TO TO TO TO TO TO TO TO TO TO	eused the de on each line 3 21 R AS A CONSECT R AS A CONSECT R AS A CONSECT Peth but not r	Peath. Do not entail. OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OTHER	REHART - ECH. O. Box 56 In the mode of dying, su Inderlying ceuse given in 28. PLACE OF DEATH (6)	n Part I. 24a. WAS AN PERFO	RAL H	Approximet Interval Bet Onset and On				
PHYSICIAN: MEDICAL	shock, or heert failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions DID TOBACCO USE Case was case Reference to Medical Exampler?	DUE TO (OF DUE TO TO TO TO TO TO TO TO TO TO TO TO TO	eused the de on each line J 21 R AS A CONSECT R AS A CONSEC	Peath. Do not entail. OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OTHER	INAME AND ADDRESS OF IREHART—ECH. O. Box 56 If the mode of dying, such that mode of dying, suc	n Part I. 24a. WAS AN PERFO	RAL H	Approximet Interval Bet Onset and Onset and Approximet Interval Bet Onset and Onset and Approximet Interval Bet Onset and Onset and Onset and Onset and Onset and Onset and Onset Interval Interval Interval Interval Interval				
MEDICAL	shock, or heert failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificant conditions DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER F DEATH 1 Natural 5 Pending	DUE TO (OF DUE TO (OF	eused the de on each line 3 21 R AS A CONSECT R AS A CONSEC	Peath. Do not entail. OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF): OUENCE OF):	ATH YES Needlence So Part Not	n Part I. 24a. WAS AN PERFO 1 YES:	AUTOPSY RMED? INJURY OCC	Approximet Interval Bet Onset and Onset and Approximet Interval Bet Onset and Onset and Approximet Interval Bet Onset and Onset and Onset and Onset and Onset and Onset and Onset Interval Interval Interval Interval Interval				



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE POSTING OF A TROUGHOUR THE JAM PROPERTY OF THE JAM PROPERTY OF THE JAM PROPERTY OF THE JAM PROPERTY OF THE JAM PROPERTY OF THE JAM PROPERTY OF THE FUNCTION. THE JAM PROPERTY OF THE FUNCTION TO THE FUNCTION THE STATE OF THE JAM PROPERTY OF THE STATE OF THE JAM PROPERTY OF THE STATE OF THE JAM PROPERTY OF THE JAM PROPER
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										90) U	1903	
	FOR 1 - STATE REGISTRAR	STATE OF M	ARYLAND) / DEPAR	TMEN ICAT	T OF H	EALTH AND DEATH	MEI	NTAL HYGIEN REG. NO.				
	1. DECEDENTIS NAME (Ast, Middle, Last)	_A		LEK	2012	E			DATE OF DEATH DATE OF	519	95	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs.		IF UNDE	R t YEAR	IF UNDER 24 HRS.	_ /	DATE OF BIRTH (Month, Day, Year)		Country	PLACE (State or Foreign	
	220 - 42 - 0763	1 M 2 X F	49	YRS.	YRS.			M	ar 24, 1	945			
œ	9a. FACILITY NAME (If not institution, give si					_	R LOCATION OF	DEATH		JNTY OF DE			
6	Laurel regional H	ospital		Laurel						eorge			
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY	
ā	Maryland Howard	đ		Da	yton							LIMITS? 1 YES 2 X NO	
¥	10e. STREET AND NUMBER					101	ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?	
	4850 Green Bridge	Road				2.	1036			US.	A		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT OF HISP/	ANIC O	RIGIN? (Specify Yes	or No-	14. RACE	- American Indian, White, etc.	
<u> </u>	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WA		M. III			2 X NO Spec		erro riceri, etc.)		Specify	r:	
	15. DECEDENT'S EDUC	CATION	140-	25050511710							Whit	te	
COMPLETED	(Specify only highest grade Elementery/Secondary (0-12)	completed)		(Give kind of a life. Do NOT us	VORK done	during mos	N st of working		16b. KIND OF BUS	SINESS/IN	DUSTRY		
	Grade 12	College (1-4 or 5+)		School					Bus Com	nanv	Cont	ractor	
S	17. FATHER'S NAME (First, Middle, Last)			CHOOL	Dab	DLI		AME /	First, Middle, Maiden		COITE	Lactor	
	Joseph Bowman						Margie						
DE.	t9a. INFORMANT'S NAME (Type/Print)			196. MAILING	ADDRES	S (Street a			Number, City or Town	n, State, Zi	D Code)		
2	A. Richard LePore								ayton, M			1036	
	20e. METHOD OF DISPOSITION 1 🔀 Burlel 2 🗆 Cremetton 3 🗀 Remo	-14	20b. PLA	CE AND DATE	OF DISPOS	SITION (Na	me of	1			City or Tow		
	4 Donation 5 Other (Specify)	ovair from State	Par	klawn	Ceme	etery	7	3	3/9 Rock	cvil	Le, Ma	aryland	
Ì	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22.	NAME AN	D ADDRESS OF F		Y				
	I Shitten X	hull							al Home, . Laurel			J 20707	
	23. PART I. Enter the diseases, or c	omplications that	caused tha	desth. Do n	not enter	r the mo	de of dying, au	ch aa	cardiec or read	ratory ar	reat.	Approximate	
ŀ	ahock or Heart fallure. I	List only one caus	e on each I	ine.						,		Interval Between Onset and Death	
- 1	disease or condition	12	ISPI	NATI	DRY	1 1	TURE	3-1				460	
ı	resulting in death)	DUE TO	OR AS A CON	CONSEQUENCE OF):							(1113		
2		DUE TO (OR AS A CONSEQUENCE OF): MASSIVE AS PINATION OF									14hr		
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF): GASTUC CONTENTS											
HIFICATION	CAUSE (Disease or Injury	2					0/12/1						
	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE OF	F):								
Į I		l										-	
	PART II. Other algnificent condition	contributing to d	leath but no	t resulting i	n the ur	nderlying	cause given in	n Part				WERE AUTOPSY FINDINGS	
EDICAL									PERFOR		- -	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
ME									1		Į.	DF DEATH?	
- 11	DID TOBACCO USE CONTR	RIBUTE TO CAL	ISE OF DI	EATH YE	s 🗆	NO 🔀	UNCERTAI	IN [
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSBITAL	26. PL	ACE OF DEAT									
7) 1 YES 2 NO 1 Supportient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specific)													
27. MANNEB OF DEATH 280. DATE OF INJURY (Month, Day, Year) 280. TIME OF 1NJURY AT WORK? 280. DESCRIBE HOW INJURY OCCURE (MOnth, Day, Year)								CURED					
5	1 Netural 5 Pending Investigation				M		ES 2 NO						
3	3 Suicide 6 Could not be determined	28e. PLACE OF building, et	INJURY — At tc. (Specify)	home, ferm, a	treet, fec	tary, office		281.	LOCATION (Street e City or Town, State)	nd Numbe	r or Rurel Ro	ute Number,	
MFCE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of m	y knowledge.	death occurre	d et the t	time, date	end piece, and du	e to the	couselet and man	ner en et-	ted.		
5	one) 2 MEDICAL EXAMINER											and menner as stated.	
3	296. SIGNATURILAND TITLE OF PURTIFIER	-	i de la companya de l	1	gnan		29c. LICENSE NU					Month, Day, Year)	
	1 1 190	ya D	In	N	M		1)24	74	2	M	1AR	5 95	

Compron MD 8317 Charry Lane Laurel MD 2070 ACOMPTON MI)
32. RESISTRARYS SIGNATURE
Julia abustion hardall

31. DATE FILED (MORTH, Day, Your) 1995

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1.		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
÷	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	REGISTRAN		CER	HIER	JAIL	F DEAL	н	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) JOSEPH	FLEURY		LOU	GHUN			2. DATE OF DEATH MONTH MAR 5	1995	YEAR	3. TIME OF DEATH 3:55 pm
ý	4. SOCIAL SECURITY NUMBER 213–38–9180	1 x w 2 □ F 5	(In yrs. last bir	- "	F UNDER 1 YEAR			7. DATE OF BIRTH (Month, Day. Year) Apr. 26,19	937	Country	PLACE (State or Foreign yland
N.	9e. FACILITY NAME (If not institution, give at Saint Joseph Med	reet and number)		1	9b. CITY, TOWN	OR LOCATION	N OF DEA	ATH .		NTY OF DE	
ਰ	RESIDENCE OF DECEDENT						_				
DIRECTOR	10a. STATE 10b. COUNTY Maryland	Harford	10		ingdor				-		10d. INSIDE CITY LIMITS?
4	10e. STREET AND NUMBER	narrora		AU		10f. ZIP CODE	_		10- OIT	1750 05 10	1 ☐ YES 2 💢 NO
FUNERAL	3800 Maryland Av						009			J.S.A	
5	11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Married	12. WAS DECEDENT EVER IN FORCES? 1 YES)	13. WAS D	ECENDENT OF	HISPANI	C ORIGIN? (Specify Yes , Puerto Rican, atc.)	or No-	14. RACE	- American Indian, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D				ES 2 X NO				Spec#	y:
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECED	ENT'S US	SUAL OCCUPA	TION		16b. KIND OF BUS	INESS/INC	DUSTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do	NOT use i	rk done during i retired.)	nost or working	,				
COMPLETED	12	0	Sales	s Re	preser	tative	е	Distrib	outic	n Co	
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	ER'S NAM	IE (First, Middle, Maiden :			
BE	Edward Loughlin					Mar	y El:	izabeth Su	ılliv	'an	
9	19e. INFORMANT'S NAME (Type/Print)		19b. M	AILING A	DDRESS (Stree	t end Number	or Rural Ro	oute Number, City or Town	n, Stata, Zip	Code)	
۲	Mrs. Dorothy S.	Loughlin	380	M 00	arylar	d Ave	., Al	bingdon, M	aryl	and	21009
	20a. METHOD OF DISPOSITION 1 □ Buriel 2 □ Cremation 3 □ Remo	oval from State cen	. PLACE AND	DATEOF	pisposition/ or place) Luthe	Name of		0ATE 20c. LOC	CATION —	City or Tow	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	t. Pai	II.S	LUTINE	AND ADDRES	emete	ery Aber	deen	, Mar	yland
	* Busten Ac	XILLIOAL	oppi	0 0	Tarri	ng-Car	rgo 1	Funeral Ho land 2100			
	23. PART I. Enter the diseases, or c	omplications that cause	d the death.		anter tha n	node of dvir	ig. auch	as cerdiac or resolu	ratory an	rest	Approximata
	IMMEDIATE CAUSE (Finel disease or condition	CORONAR	ach line.			,		and to the same of the same	atory are		Interval Between Onset and Death
	DUE TO (OR AS A CONSEQUENCE OF): VAVULAR HEART DISEASE YEARS									YEARS	
CERTIFICATION	Sequentially list conditions, If any, leading to immediate Cause Enter INDERIVING								Hours		
IFIC/	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	AUSE (Disease or Injury on the Inflied ovents Due to (OR AS A CONSEQUENCE OF):							HOURS		
CERI	resulting in death) LAST	. nestinate	פרוו זרוי	WEE	CIEINCT						110010
	PART II. Other algnificant conditions	a contributing to deeth b	ut not reeu	Iting In	the underly	ng cause gl	van In P				WERE AUTOPSY FINDINGS
EDICAL	MULTIPLE SCLERO							1 YE\$ 2	X		AVAILABLE PRIOR TO COMPLETION OF CAUSE
밀	PERPHERIAL VAS	CULAR DISEASI	Ε					_ Tes 2	□ NU		OF DEATH?
W	DID TOBACCO USE CONTR	SIBLITE TO CAUSE O	E DEATH	VEC	Пиол	UNCE	DTAIN				1 TES 2 Mb
A	25. WAS CASE REFERRED TO MEDICAL				(Check only on		KIAIN	Ш			
2	EXAMINER?	HOSPITAL:		C	THER:		22111111				
PHYSICIAN:	27. MANNER OF DEATH	1 Simpatient 2 ER/Outp		b. TIME C			-	Other (Specify)			
BY PI	1 Retural 5 Pending 2 Accident Investigation	(Month, Day, Year)	20	INJUR	Y V	VES 2		28d. OEŞCRIBE HOW IN	JURY OCC	CUREO	
							261. LOCATION (Street or City or Town, State)	nd Number	or Rural Ro	oute Number,	
<u>w</u>	29e. CERTIFIER	NAM: To the best of an inch					(1)				
COMPLETED		CIAN: To the best of my know R: On the basis of examination									end manner es stated.
H	29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month) 3-5-6										
5	30. NAME AND ADDRESS OF PERSON WHO RICHARD L. LINTHI	CUM, M.D., 76	ATH (ITEM 27)	(Type, Pr	OAD TO	Owson	N, MA	ARYLAND 21			
ŀ	31. DATE PILLED (Month, Day Year)	32, REGISTRAR'S SIGN	ATURE	_		.					
	31. DATE THE MARY 06 1995	Julia Davelson	Rardall		¥						

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TENDING PHYSICIAN: The law requires that the death certificate be executed within, fours after death. Page 6 may be refained by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1 fer death with the State Dept. of Health and Mental Hyglene prior to buriat, cremation, or removal.	8 is marked or item 23 shows any injury or other trainmatic event the medical examines must be notified at once

										(95	0 -	7907
	FOR 1 - STATE REGISTRAR	STATE OF	MARYLAND /		RTMENT OF				MENTAL HYGI				
18	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEAT			3	L TIME OF DEATH
11		Edith .	J. Moor	e					Februar			YEAR	0740 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		IF UNDER 1 YE	\rightarrow	IF UNDER 24	HRS.	7. DATE OF BIRTH (Month, Day, Yea				LACE (State or Foreign
	166-03-6645	1 □ M 2 🔀 F	78	YRS.				22.1	Dec. 6.	191	6 I	Penn	sylvania
OC.	9e. FACILITY NAME (If not institution, give s				96. CITY, TO		LOCATION	OF DE	ATH	1.3		Y OF DEA	тн
6	208 Friendship R	oad			E1kt	on					Cecil	<u> </u>	
DIRECTOR	10e. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN OR L	OCATIO	ON					10	Od. INSIDE CITY LIMITS?
□	Maryland Ceci	1		E1	kton							1	▼ YES 2 □ NO
FUNERAL	10e. STREET AND NUMBER 208 Friendship R	o a d					ZIP CODE			10	g. CITIZE	N OF WH	AT COUNTRY?
N	11. MARITAL STATUS		NT EVER IN U.S. ARI				21921					.A.	
	1 Never Married 2 M Merried	FORCES?	VES 2 NAR OR DATES	IO MED	II yea	s, spec	elfy Cuban, I	Mexican	IC ORIGIN? (Specify n, Puerto Ricen, etc.	Yee or I	No- 14	Black, \	– American Indien, White, etc.
B	3 Widowed 4 Divorced	IF TES, GIVE	MAR OR DATES		''	YES 2	х∑ ио	Specify:				Specify:	White
	15. DECEDENT'S EDUI (Specify only highest grade		16a. DE(CEDENT'S	WORK done during se retired.)	PATION g most	of working		16b. KIND OF	BUSINE	SS/INDUS	STRY	-
۳	Elementary/Secondary (0-12)	College (1-4 or 5	+)										
COMPLETED	12 17. FATHER'S NAME (First, Middle, Last)		Ho	mema	ker		10 MOTHER	D'C NAN	AE (First, Middle, Ma	de Com			
	John R. J	ones					18, MUINER	1 S NAN					
BE (19e. INFORMANT'S NAME (Typer/Print) 19b. MAILING ADDRESS (Street end Number or Bural Route Number, City or Town, State, Zip Code)												
9	David S, Moore 208 Friendship Road - Elkton, MD 21921												
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION [Name of genetary of other place] 20c. LOCATION — City or Town, State												
	Gilpin Manor Memorial Park 1995 Elkton, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A.												
	21. SIGNAL DRE OF FUNERAL SERVICE LIC	ENSEE			22. NAM H1	CKS	S HOM	e f	or Funer	als	als, P.A.		
	Elkton, MD 21921-5521												
	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, abock, or heart feliure. List only one cause on each line. Approximate interval Between												
	iMMEDIATE CAUSE (Finel disease or condition									Onset end Death			
	resulting in deeth) a. Mchemic Cardinayopathy DUE TO (OR AS A CONSEQUENCE OF): MONTH'S									MONTHS			
z			lamada.	Ant	es. I	2	2440						vears
5	if any, leading to immediate										year		
IFICATION	CAUSE (Disease or injury												
	that initiated evante DUE TO (OR AS A CONSEQUENCE OF): resulting in danth) LAST												
CERI	d												
M	PART ii. Other aignificant condition				in the under	lying	cause give	en in F		FORMET		A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
ğ	Chronic Ren	of ins	ufficies	ney				_	1 🗆 YE	S 2 🗹	NO		OMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO TO									YES 2 NO			
AN	25. WAS CASE REFERRED TO MEDICAL			-			CE OF DEAT						
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpetient 3	□ DOA	OTHER:	Home	5 Resid	lence (Other (Specify)				
H	27. MANNER OF DEATH	28a. DATE Of	F INJURY Day, Year)	28b. TIM	IE OF 28c	. INJUI	RY AT		28d. DESCRIBE HO	W INJU	RY OCCU	RED	
BY	1 Natural 5 Pending 2 Accident Investigation					_ YE	S 2 N	10					
	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE (building	OF INJURY — At hor , etc. (Specify)	me, farm,	street, 1ectory,	office			28f. LOCATION (Str. City or Town, S	eet end l tate)	Number or	Rural Rou	ute Number,
H	AND CERTIFIED					_	_						
COMPLETE	(Check only one) 1 CERTIFYING PHYSI (Check only one)												
	29b. SIGNATURE AND TITLE OF CERTIFIER		The state of the s	vaugan	, in my opini					1			
BE	Monte Mikon	•				1	29c. LICENS		783	29			Aonth, Day, Year) - 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH JUTEM 277 (Sing Grice)									~	-,			

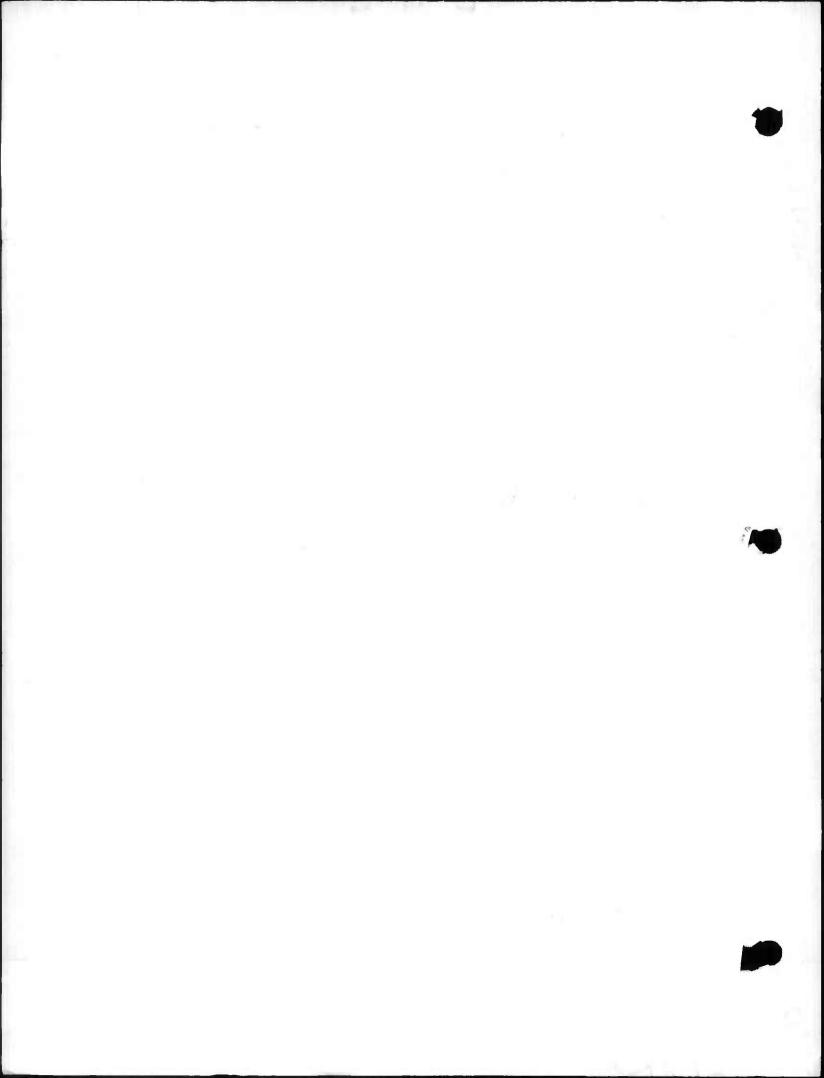
ELKTON, MO

MONTE	MAK045			Bridge	CT	
7	1 4111-40	7-10	/	Driage	21.	1

32. REGISTRAR'S SIGNATURE
The Davidson-Randall

DHMH-18 Rev 1/89

2/921



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within any hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 29 heurs after death with the State Dear of Health and Mental Houlene prior to bring remaining or removal.
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	1 . STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIEN	E						
	REGISTRAR CERTIFICATE OF DEATH	REG. NO							
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH MONTH DA	AY YE	3. TIME OF DEATH					
	Edna T. Mix	Feb. 16,	1995	6.15AM M					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign					
1	218-10-1319 1 M 2 K 73 YRS. MONTHS DAYS HOURS MIN.	April 19, 1	- 1	Country) Tirginia					
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DI		9c. COUNTY						
<u>ac</u>			Cecil						
16	V.A. Medical Center Perry Point		Cecii						
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION			10d, INSIDE CITY					
1 5	D.C. D.C. Washington, D.C.			LIMITS?					
	10e. STREET AND NUMBER		40. 0	1 X YES 2 NO					
RA	101.217 0002		100	OF WHAT COUNTRY?					
FUNERAL	ZIZZ I Beleet, it, aper		U.S.						
<u> </u>	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPAI 1 Newer Married 2 Married 15. WAS DECENDENT OF HISPAI 17. YES 2 NO If yes, specify Cuben, Mexica		or No- 14.	RACE — American Indian, Black, White, etc.					
B≼	IF YES, GIVE WAR OR DATES 1 ☐ YES 2 X NO Specific			Specify: White					
	1 1944 - 1945			WILLE					
윤	15. DECEDENT'S EOUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUS	SINESS/INDUST	TRY					
<u> </u>	Elementary/Secondary (0-12) College (1-4 or 5+) life. Do NOT use retired.)								
. Ē	2 Detective	Law En	forcem	ent					
COMPLET	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NA	ME (First, Middle, Meiden	Surname)						
. III	Aaron Travis	Nina Thor	nas						
BE	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural	Boute Number City or Tow	n State Zin Cor	fe)					
TO BE	V.A. Medical Center Perry Point, MD 2196		ii, Stato, Esp Oot	~,					
8	Valle Hedded Geneel								
MUSI	1 X Buriel 2 Cremetion 3 Removal from State	22-23		or Town, State					
		1995		Maryland					
medical examination	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FA	Tor Funera	ls, P.	Α.					
Тех	103 West St	ockton Str	eet						
100	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auc								
	ahock, or heart failura. Liat only one cause on each line.	n aa cardiac or respi	ratory arrast	Approximate interval Between					
	IMMEDIATE CAUSE (Final			Onset and Death					
event, me	disease or condition Chronic Renal Failure								
	DUE TO (OR AS A CONSEQUENCE OF):								
	Hypertension								
2	Sequantially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
N N	cause. Enter UNDERLYING Diabetes Mellitus								
E E	CAUSE (Disease or Injury that initiated evanta DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST								
	d,								
3	PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS					
2	Schizophrenia	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE					
E		1 X YES 2	□ NO	OF DEATH?					
PHYSICIAN: MEDICAL C				1 TYES 2 NO					
AN.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	NXX							
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? ACCESS REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
YSi	1 YES 2 NO HOSPITAL: OTHER: 4 Nursing Home 5 Residence	8 Other (Specify)							
£	27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT	26d. DESCRIBE HOW I	NJURY OCCUR	ED					
BY PH	1 (Month, Day, Year) INJURY WORK? 1 (Month, Day, Year) INJURY WORK? 1 VES 2 NO								
	28e PLACE OF INITION — As home form street feature office	28f. LOCATION (Street o	and Number or F	Bural Route Number					
	Suicide B Could not be building, stc. (Specify) Description	City or Town, State)							
	29e. CERTIFIER								
1	(Check only 1 (C								
0	one) 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the	time, date end place, en	d due to the ce	puse(e) end menner ee stated.					
29d. DATE SIGNED (Mogh. Dis.									
	200. LICENSE NO								
D BE COMPLE	H4106:	1112320	D 21	16/95					

M. D., VAMC, PERRY POINT, MD., 21902

32. REGISTRAR'S SIGNATURE

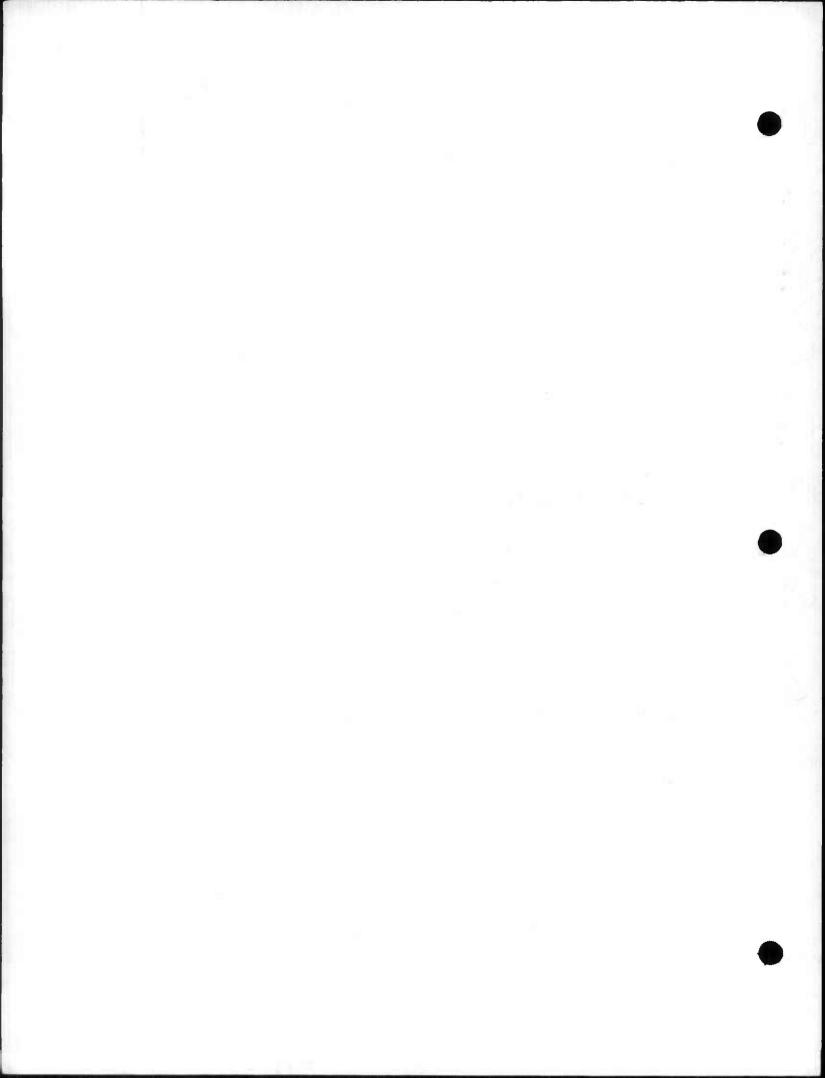


STANLEY KMAN,
31. DATE FILED (Month, Day, Year)

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fine feath. Page 6 may be retained by the hospital or attending physician.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should	444
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND / DE	PARTMENT OF H		ENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)	nily Elizabeth M	100		MONTH DEATH 2	Y YEAR	3. TIME OF DEATH A		
	4. SOCIAL SECURITY NUMBER 5. S 222-12-3293 9a. FACILITY NAME (If not institution, give street as	M 2 ☑ F 93 Y	RS. MONTHS DAYS		DATE OF BUTTH (Month, Day, Year)	8. BIF	TTHPLACE (State or Foreign intry) Laware OBATH		
стов	Union Hospital of C	ecil County	E1kton		1	Cecil			
FUNERAL DIRECTOR	Maryland Cecil	100	e. CITY, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 X NO		
ERAL	100. STREET AND NUMBER 24 Misty Meadow Lan	ie	101	. ZIP CODE 21904		U.S.A	F WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 12. 1	WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO F YES, GIVE WAR OR DATES	If yes, sp	ENDENT OF HISPANIC colfy Cuban, Maxican, if 2 NO Specify:		GIN? (Specify Yea or No. 14. RACE - An			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete formularly/Secondery (0-12) 1 2	(Give kii Hege (1-4 or 5+)	ENT'S USUAL OCCUPATION of of work done during monor use retired.) maker	ON st of working	16b. KINO OF BUS	SINESS/INDUSTRY			
	17. FATHER'S NAME (First, Middle, Lest) William H. G		maker		(First, Middle, Maiden	,			
) BE	19a. INFORMANT'S NAME (Type/Print)		ILING ADDRESS (Street a		Sarah E. Ite Number, City or Town				
2	Alice Buchanan	11	Brownfield	Loop - E					
7	20s. METHOD OF DISPOSITION 1\(\) Burial 2 \(\) Cremailon 3 \(\) Removal fi 4 \(\) Donation 5 \(\) Other (Specify)	rom Stata cemetery, cremator	DATE OF DISPOSITION (Nearly or other place) Wn Memoria		フーフフト	Castle			
	21. SIGNATURE OF FUNERAL SERVICE LICENSE		22. NAME AI Hick 103	NO ADDRESS OF FACIL S Home for West Stoc	r Funeral kton Stre	s, P.A.	,		
	23. PART I. Enter the disease, or comp shock, or heart failure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death)	Peritonits.	ICE OF):	de of dying, such a	is cardisc or respi	ratory arrest,	Approximste Interval Between Onset and Daath		
CERTIFICATION	Sequentisily list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST b. Supus (out to (or As A consequence of): Puss								
PHYSICIAN: MEDICAL CI	PART II. Other algnificent conditions cor			0 .	24a. WAS AN PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
N. N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO								
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	OTHER:	ACE OF DEATH (Check					
ву Рнуз	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	1	b. TIME OF 28c. INJ	e 5 Rasidenca 8 URY AT RK? ZES 2 NO	Bd. DESCRIBE HOW II	NJURY OCCURED			
ETED E	3 Suicide 8 Could not be detarmined	3 Suicide 8 Could not be 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, Street)							
COMPLE		To the best of my knowledge, death of the bests of examination end/or investigation.					e(a) and manner as stated.		
TO BE (296. SIGNATURE AND TITLE OF CERTIFIER Jui Chil Jalu			004823	ER		ED (Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO CON TUI Chih HSW 31. DATE FILED (Month, Day, Yeer)	MD 223 32. REGISTRAR'S SIGNATURE	(Type. Print) What ma	ui st.	Ellchen	1,140	21921		
	FEB 2 4 1995 July	Shoulen Rardall							



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RAT	REC	Urs a	E
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
SPIT	VERA	hin 7	5
9	FU	wid	TA
F	I	filed	0
2	2	8	=

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) Raiph	William M	acey			2. DATE OF DEATH		3. TIME OF DEATH 1:35P M	
Į.	4. SOCIAL SECURITY NUMBER 214-05-0452		(In yrs. last birthday)	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec 31 19	8. BIR Cou	THPLACE (State or Foreign	
E C	9a. FACILITY NAME (If not institution, give so Meridian Health C	Severr	OR LOCATION OF DEATH 9c. COL			UNITY OF DEATH			
ECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCA	TION			10d. INSIDE CITY	
DIR	MD Anne	Arundel		Annapo				1 VES XX NO	
FUNERAL DIRECTOR	228 Old Mill Bot	tom Road		10	21401			States	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3XXVIdowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1X YES IF YES, GIVE WAR OR D	2 NO	If yes, ap	ENDENT OF HISPAI ecity Cuban, Maxica 2 NO Specifi	HIC ORIGIN? (Specify Yes n, Puarto Rican, etc.)	Bia	CE — American Indian, ck, White, atc.	
COMPLEIED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use re	done during mo kired.)			SINESS/INDUSTRY		
D N	17. FATHER'S NAME (First, Middle, Last)		Carpen	ter	18. MOTHER'S NA	ME (First, Middle, Maiden	entry Sumame)		
RE C	Oliver Cromwell	Macey				ite Gladys			
2	19a. INFORMANT'S NAME (Type/Print) Peter Oliver Ma	сеу				Route Number, City or Tow Road Annap		21401	
	20s. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Rem 4 Donation 8 Other (Specific	oval from State Set	PLACE AND DATE OF C	See Chul	ch Cemet	950ATE 200. LO	CATION - City or		
	21. SIGNATURE OF MUNERAL SERVICE LIC	enset .		22. NAME A	Ouke of G		Taylor F	uneral Home	
	23. PART I. Entar the diseases, prospective shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Reve	d the death. Do not ach line. L Full CONSEQUENCE OF):	-	de of dying, auc	h as cardiec or reap	iratory arreat,	Approximate interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST	c	CONSEQUENCE OF):						
MEDICAL	PART II. Other algnificant condition	a contributing to death b	out not reaulting in t	he underlyin	g ceuse given in	Part I. 24s. WAS AN PERFOR	RMED?	Ib. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
NN	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O			UNCERTAI	VO			
HISICIAN	EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF DEATH (a 5 🗆 Residence	8 Other (Specify)			
Lui	27. MANNER OF DEATH 1 Heteria 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c, INJ WC		28d, DESCRIBE HOW INJURY OCCURED			
בובה	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, stree	rt, fectory, offic	•	28f. LOCATION (Street a City or Town, State)		Route Number,	
COMPLE		CIAN: To the best of my know. R: On the bests of examination						(s) and manner as stated.	
0 00	29b. SIGNATURE AND TITLE OF CERTIFIER	lie	Atked		29c. LICENSE NUM	776		o (Month, Day, Year) uary 21, 1995	
	Surya Mundra, M.D			•	106 Glen	Burnie. M	D 21016	(410-768-4242)	
	31. DATE FILED (Month, Day, Year) FEB 2 8 1995	31. REGISTRAR'S SIGN	Randall					,	

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First, Middle, Last											
	A CONTRACTOR OF THE STATE OF TH	M. Marsl	hall					2. DATE OF MONTH Febru	DEATH	24, 1	895	2:12
	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. lest birtho	day) IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTN		_	LACE (State or Fo
	218-14-2487	1 M 2 - F	79 YR	MONTHS	DAYS	HOURS	MIN.	July	ey, Year)		Country)	
	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY	Y, TOWN OI	R LOCATIO	N OF DE		J, 13	9c. COUNT		
E I	Edw.W.McCready		Hospital		risf				22	-	erse	
DIRECTOR	RESIDENCE OF DECEDENT			1								
H	10a. STATE 10b. COUN		10c.	CITY, TOWN			Ewe]	11	1.			10d. INSIDE CITY
		Somerset		(50				ones R	oad)			1 YES 2 2
FUNERAL	100. STREET AND NUMBER 20902 Caleb	Jones Road	d		101.	2182			Mi-		JSA	HAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARMED	13.	WAS DECE	ENDENT O	F NISPAN	IIC ORIGIN? (S	Specify Yee	or No- 1	4. RACE -	- American India
BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W			1 TYES						Specify	
	15. DECEDENT'S ED	UCATION	16e, DECEDER	NT'S USUAL O	CCUPATIO	N		16b. KH	ND OF BUS	INESS/INDU:	STRY	**************************************
ETE	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 8 +	(Give kind	d of work done OT use retired.)	during mos	st of working	9					Res ou
P	Grade 7			te						Vesse		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							ME (First, Midd				
BE C	Edward Watson	Marshall	N 271-			E	liza	abeth	Marie	Evan	ns .	
TO B	19e. INFORMANT'S NAME (Type/Print)			LING ADDRES							Code)	
F	Maxine Evans (d	laughter)	P	. O. E	30x 7	/ - E	wel]	L, MD	21	824		
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Re	movel from State	20b. PLACE AND D	ATE OF DISPOS	SITION (Nan	me of		DATE	20c. LOC	CATION — CI	ty or Tow	n, State
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE 1		Ewell C	hurch	Ceme	etery	2/	/28/95	Ew	vell,	MD	
	23. PART i. Enter the diseases, or shock, or heart failure iMMEDIATE CAUSE (Finel disease or condition resulting in death)	aa.	caused the death. I se on each line.	no not anter	r the mod	de of dyli	ng, aucl	St	Cris	Sfield	a, MI	Approxim interval B
RTIFICATION	ahock, or haert failure iMMEDIATE CAUSE (Fine) disease or condition	a. DUE TO (caused the death. I se on each line.	Do not enter	r the mod	de of dyli	ng, aucl	St. — h as cerdled	Cris	sfield	at,	Approximinterval B
CERTIFICATION	shock, or haert failure immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (caused the death. I se on each line. COR AS A CONSEQUENCE (OR AS A CONSEQUENCE (OR AS A CONSEQUENCE (OR AS A CONSEQUENCE (OR AS A CONSEQUENCE	Do not enter CE OF): CE OF):	r the moo	the	g, auct	fun	Cris	Sfield	1 , MI	D 2181 Approximinterval Bi Onset and
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AN: MEDICAL C	ahock, or haert failure iMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions	a. DUE TO (caused the death. I se on each line. COR AS A CONSEQUENCE (OR AS A CONSEQUENCE (OR AS A CONSEQUENCE (OR AS A CONSEQUENCE (OR AS A CONSEQUENCE	Do not enter CE OF): CE OF):	nderlying	de of dyli	ng, auci	Part I. 24	WAS AN A PERFORM	AUTOPSY MED?	24b. \	Approximinterval Bionset and Onset a
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. D. Doo 7 - Coll . . . to bus BY - februaries 308 W. Main St. - Colorado, and East? TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician.

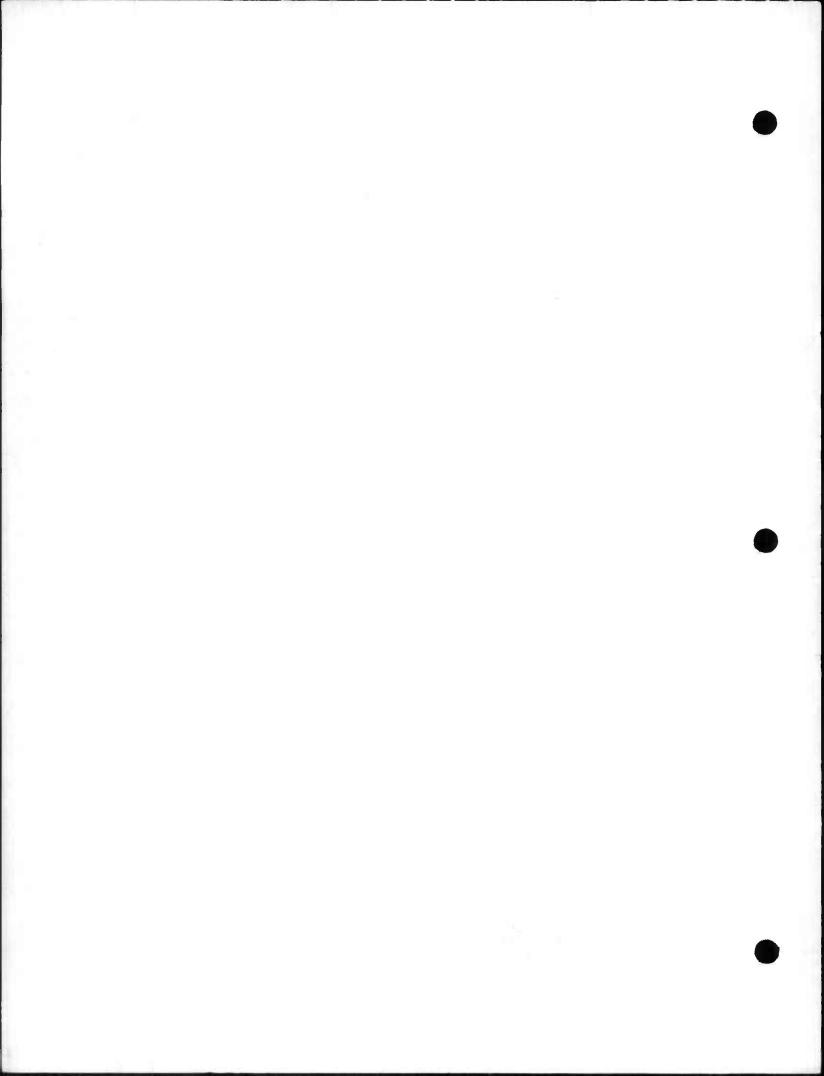
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF H	EALTH AND MI	ENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last))	OLITTI	OAIL OI	T	2. DATE OF DEATH		3, TIME OF DEATH
0	BETTY W.	MASSEY				Feb. 22	1995	2:15 A M
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE ((In yrs. last birthday)	IF UNDER 1 YEAR		DATE OF BIRTH	8, BIRT	HPLACE (State or Foreign
	213-22-6882	1 □ M 2 🔽 F 69	YRS.	MONTHS DAYS	HOURS MIN.	8-31-25	Ma	ryland
_	9a. FACILITY NAME (If not institution, give	street and number)		96. CITY, TOWN C	R LOCATION OF DEAT	Н	9c. COUNTY OF	DEATH
DIRECTOR	Home Rt 3, Box	x 159		Galesto	wn		Dorchest	er
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	10c, CITY	, TOWN OR LOCAT	ION			10d, INSIDE CITY
뜸	Maryland Dorch	hester		stown				LIMITS?
	10e. STREET AND NUMBER	Hebeel	parc		. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	Rt 3 Box 159;				19973		US	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPANIC	ORIGIN? (Specify Yes	or No.— 14, RAC	E — American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES			ecify Cuban, Maxican, 2 ⋈ NO Specify:	Puerto Rican, atc.)	Spe	
						7		white
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	de completed)	18a. DECEOENT'S (Give kind of w	USUAL OCCUPATION Nork done during more orea retired.)	ON st of working	16b. KIND OF BU	SINESS/INDUSTRY	
PE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Sale3s			Retail	Sales	
O	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME	(First, Middle, Maiden	Sumame)	
ш	George Wheatley				Elsie J			
0 8	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural Rou			
F	Lee R. Massey		Rt 3 B	ox 159;	Seaford,	De. 1997	73	
	20a. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Ref	moval from State 20b	PLACE AND DATE O	F DISPOSITION (Na	me of		CATION — City or T	
	4 Donation 5 Other (Specify)		dd Fello			25/95 Sea	ford, De	•
	Salva Cel	Memolio			ton Funer			
	John A. Cran			POE	ox 967. S	eaford. I	e. 19973	3
	23. PART I. Enter the diseases, or shock, or heart fellure	r complications that caused . List only one cause on a	d tha death. Do n ach lina.	ot anter tha mo	de of dying, auch a	na cardiac or reap	ratory errest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	T.	6 1	in C	7	un for	7.4	Onset and Death
	resulting in death)	0.			5-14			hour
		DUE TO (OR AS A	CONSEQUENCE OF) E	Brdop	سرد	should	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	7:	1	-		
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	c	AD	c -	200 Euce	verl	voc hu	235
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	ŋ:			-	1310
ER	resulting in death) LAST	d. // \	101)				5
AL C	PART II. Other algolficent condition	ons contributing to death b	out not resulting i	n the underlying	ceusa given in Pa	ert I. 24a. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS
						PERFOR	IMEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						_ 1 1 1 1 2 2	2 NO	OF DEATH?
						_		
NA I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF OEATH (Check	only one)		
SIC	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3 DOA	OTHER: 4 Nursing Hom	e 5 Residence 8	Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIMI INJ		URY AT 2 RK?	8d. OEŞCRIBE HOW I	NJURY OCCURED	
B	1 Natural 5 Pending 2 Accident Investigation	The second secon			rES 2 NO			
ED	3 Suicide 8 Could not be 4 Homicide determined	284. PLACE OF INJURY building, etc. (Scient	Al home, farm, a	treet, factory, offic	2	8f. LOCATION (Street of City or Town, State)	and Number or Rural	Route Number,
E								
COMPLET	(Check only one) 2 MEDICAL XAND	SICIAN: To the best of my security	and/or investigation	d at the time, date	and place, and due to	the cause(a) and mai	oner as stated.	3) and makes as almost
	29b. SIGNATURE AND TITLE OF CAUTIFIE	1 / //		,, .,				
BE	777	7 8 1			D 204			8-95
5	30. NAME AND ADDRESS OF BESSON W	HO COMPLETED CAUSE OF OE	ATH (ITEM 27) (Type,	Print)	5 200			- 0-
	Joseph K. RA	Affetto . P	o Dox 4	9 SAlic	101.011 10	22803		
	31. DATE FILED (Month, Day, Year)	22/AUGISTBAH'S NON	ATUGO	1 00111	wicky in	42 4460		
		// / NA . I						
	FEB 2 8 199!	5 Jahr Dawes	n harfall)



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

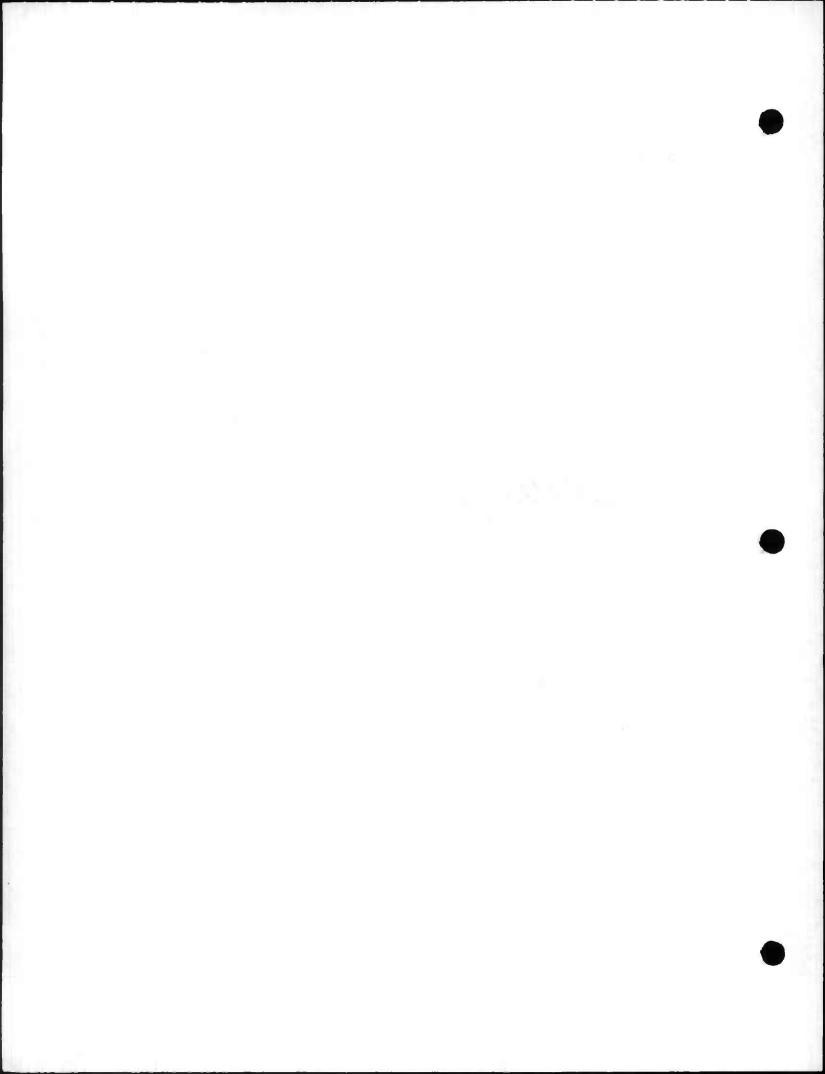
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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			ICATE OF	PEALL	HE	G. NO.		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE			3. TIME OF DEATH
SYLVESTER	MAXWELL	MILLE	ER III		Februar	y 22, 19	95	4:15
4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH	8. BIRT	HPLACE (State or Foreign
245-44-4085	11 M 2 - F	72 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day,	4, 1923	Coun	ryland
9n. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN	OR LOCATION OF D			OUNTY OF	
Main St.			Mard	ela Spri	ngs		icomi	
RESIDENCE OF DECEDENT								
10a. STATE 10b. COUNTY			Y, TOWH OR LOCA					10d. INSIDE CITY
Maryland Wicon	mico	Ma	rdela S	prings				1 K YES 2 NO
10e. STREET AND NUMBER			10	f. ZIP CODE		10g. (CITIZEN OF	WHAT COUNTRY?
Main St.				21837			USA	
	12. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS DE	ENDENT OF HISPA	NIC ORIGIN? (Spe	cify Yea or No-	- 14. RAC	E — American Indian, ik, White, atc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	FORCES7 1 X YE	DATES		ecify Cuban, Maxic		etc.)	Spec	
3 Widowed 4 Divorced	WW	II					Whi	
15. DECEDENT'S EDUCA (Specify only highest grade of		16a. DECEDENT'S	USUAL OCCUPATI	ON at wasking	16b. KIND	OF BUSINESS	INDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)		vork done during mi e retired.)					
10		Refrige	ration	engineer	H	ospital	L	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, Middle,	Maiden Surnam	n)	
Sylvester Maxwe	ll Miller D	[I		Eunice		Lamb)	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Flural	Route Number, Cit	y or Town, State,	Zip Code)	
Jessie Coleman		P.o.	Box 49	, Mardel	a Sprin	gs, MD	2183	7
20e. METHOD OF DISPOSITION 1 1 Burlel 2 Cremetion 3 Ramov		206. PLACE AND DATE O		arne of	DATE	20c. LOCATION	— City or T	own, State
4 Donation 5 Other (Specify)		emetery, cremetory or ot Mardela Mem	orial Ceme	eterv	2/26	Marde	la Sr	rings, MD
21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAME A	ND ADDRESS OF FA	CILITY		Id of	rings, m
1116/11	1, 1	2		oway Fun				
W. N.	un,	<i>Y</i>	501	Snow Hil	1 Rd.,	Salisbu	iry, l	4D 21801
23. PART I. Enter the diseases, or co shock, or heart failure. Li	mplications that offur st only one pause on	sed the death. Do n each line.	ot enter the mo	de of dying, suc	th as cardiac o	r respiratory	arrest,	Approximate Interval Between
IMMEDIATE CAUSE (Fine)		Second Contracts						Onset and De
disease or condition resulting in death)	Caroli	S A CONSEQUENCE OF	st					MINS
	DUE TO (OR AS	S A CONSEQUENCE OF	7:					
- *******	Cohun	u Wyged	un flu	ut Far	lul			NITTES
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	S A CONSEQUENCE OF	7:					1,110
CAUSE (Disease or injury								
that initiated events resulting in deeth) LAST	DUE TO (OR AS	A CONSEQUENCE OF	7:					
d.								
PART ii. Other significent conditions	contributing to death	but not resulting i	n the underlyin	course sives in	Part I are 1	WAS AN AUTOPS	w [a.e.	
Emplyson		Bruch		g cause given in	Pert 1. 248.	PERFORMED?	240	AWAILABLE PRIOR TO
- O O O O O O O O O O O O O O O O O O O	C. Collection	V 12 00000	NALL		1 🗆	YES 2 1-NO		COMPLETION OF CAUSE OF DEATH?
5/5								1 YES 2 NO
DID TOBACCO USE CONTRI	BUTE TO CAUSE			UNCERTAI	N 🗆 📗			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEAT	H (Check only one) OTHER:					
1 D YES 2 NO 1	I Inpatiant 2 Project	utpatient 3 🗆 DOA		e 5 - Residence	8 Other (Spec	etfy)		
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year	Y 285. TIME		URY AT	28d. DESCRIBE	HOW INJURY	OCCURED	
1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
3 Suicide 8 Could not be	28a. PLACE OF INJUI building, etc. (S)	RY — At home, term, s	treet, factory, offic		281. LOCATION	(Street and Num	ber or Rural	Route Number,
4 Homicide determined		,			City or Town	i, Stelle)		
290. CERTIFIER 1 DEERTIFYING PHYSICI	AN: To the best of my kno	owledge, death occurre	d at the time des-	and place and div	to the seconds	and messes	eteta d	
(Check only one) 2 MEDICAL EXAMINER:	On the basis of examinat	tion end/or investigation	n. In my opinion d	eath occured at the	time deta and a	ing manner as t	the course	a) and manner or start of
			., my spinion, t					
296. SIGNATURE AND TITLE OF CERTIFIER	1.00	110		29c. LICENSE NUI				(Month, Day, Year)
- 111	· COUTY	M		D /	0688		2 - 2	7-75
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF I	DEATH (ITEM 27) (Type,	Print)					
31. DATE FILED (MODIF), Day, 1697) FEB 2 7 1995	32 AGGISTRAP'S SIC							



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

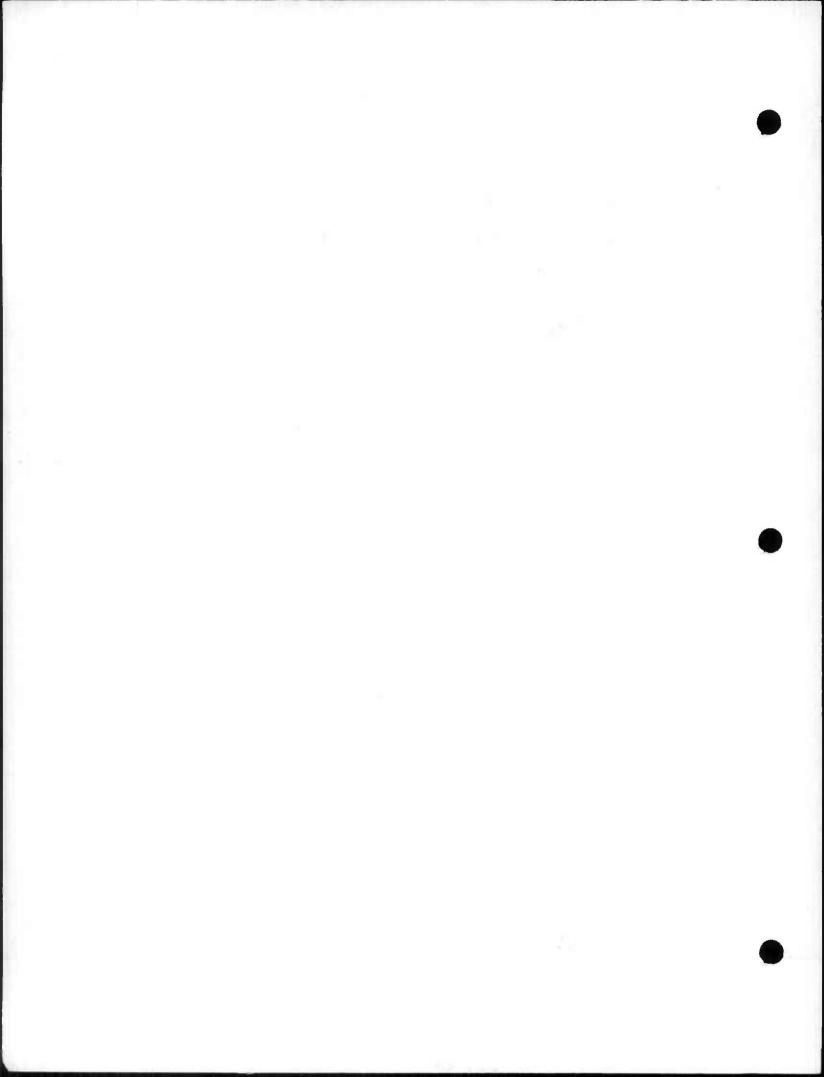
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAR		CERTIF	ICATE	F DEATH		REG. NO.			
- 8	1. DECEDENT'S NAME (First, Middle, Last)					2	2. DATE OF DEATH	v	YEAR	3. TIME OF DEATN
	Elizabeth Harr	iet Marvel					02-16-9		T.C.A.II	2200 M
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YE			7. DATE OF BIRTH			PLACE (State or Foreign
- 3	220-01-2590	1 M 2 PF	73 YRS.	MONTHS DA	YS HOURS M	IN.	(Month, Day, Year) 03-21-2	1 I	Country	yland
	9a. FACILITY NAME (If not institution, give	street and number)	75	9b. CITY. TO	VN OR LOCATION O	DE DEAT			NTY OF DE	
c	D		3 61				-			
l 유 l	Peninsula Regi	onal Medic	al Ctr	palis	bury	_		WIC	omic	:0
DIRECTOR	10a. STATE 10b. COUNT			Y, TOWH OR L						10d. INSIDE CITY
盲	Md. Wi	comico		Sali	sbury					LIMITS? 1X YES 2 NO
1	10e. STREET AND NUMBER			Dull	10f. ZIP CODE			10a, CITI		HAT COUNTRY?
FUNERAL	610 Lincoln Av	۰.			2180	11			11 6	. A .
<u>₹</u>	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13 WAS			ORIGIN? (Specify Yea	or No		- American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes	, specify Cuban, Me	exican, i		0	Black,	White, atc.
B	3 💢 Widowed 4 🗌 Divorced	IF YES, GIVE WAN ON I	AIES	1	YES ZY NO S	ipecny:			Specify	White
0	15. DECEDENT'S EDI	ICATION	18a. DECEDENT'S	USUAL OCCU	PATION		16b. KIND OF BUS	INESS/IND	USTRY	WII.166
ᄪ	(Specify only highest grade Elementary/Secondary (0-12)	College (t-4 or 5+)	life. Do NOT u	work done durin se retired.)	most of working					
I I	11		Housew	ife			Own	Но	me	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	S NAME	(First, Middle, Maiden			
ш	Marvin Thomas	Gladden			Agne	25 (Cox			
8	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (Str			ute Number, City or Town	n, State, Zip	Code)	
임	Wanda Waller		901	Ellis	Pkv .	De	lmar, De	1 3 5.5	220	10040
	20a METHOD OF DISPOSITION 1 A Burial 2 Cremellon 3 Rem	20	PLACE AND DATE	OF DISPOSITIO	V/Name of		DATE 20c LO	CATION -	City or Ton	on Clate
	1 A Burial 2 □ Cremellon 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	netery, crematory or o	de la	Cometer	- 17	2/10 Mar	301	- En	rings, Md
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	^	22. NAN	E AND ADDRESS O	OF FACIL	TAL TO LIGIT	der	2 30	LINUS, MO
1	5	1/2	0/							
\vdash	Muala	1 odun		Bou	nas Fun	era	al Home,	Sa	lisb	ury, Md.
	23. PART I. Enter the diseases, or ahock, or heart failure.	Complications that cause List only one cause on a	d the daath. Do i	not anter the	moda of dying,	such s	ss cardiac or raspi	ratory arr	rest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final									Onset and Death
	disease or condition reaulting in death)	a. Pneumoni DUE TO (OR AS	tis				-91			hours
No.	Sequantially list conditions,	. Congesti	ve Hear	t Fai	lure					5 days
CERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING	Arterios		,	a:		an Diaan			
윤	CAUSE (Disease or Injury		A CONSEQUENCE O		ulovasc	Juli	ar Disea	ise		years
Ē	that initiated evants resulting in death) LAST			,						j
l iii		d								+
	PART II. Other significant condition	ns contributing to death	but not resulting	in tha under	ying cause give	n in Pa	art i. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
DICAL	Fractured lef	t hip Di	abetes	Melli	tus		t YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE
l m l	cerebrovascul	ar acciden	t.				_ ' ' ' ' '	4-110		OF DEATH?
Σ.	DID TOBACCO USE			DEATH	YES 🖂	NO	ml			1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	T			B. PLACE OF DEATH	H (Check	controne)			
) 	EXAMINER? 1 YES 2 NO	HOSPITAL:	neticet 2 DOA	OTHER:						
ΙžΙ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIN		Nome 5 - Reside		Sd. DESCRIBE NOW II	HILIBA UCA	CUREO	
1 70	t Natural 5 🗋 Pending	(Month, Day, Year) 01-27-95	JN.	JURY	WORK?	, I_				
B	2 X Accident Investigation 3 Suicide Could not be	28a. PLACE OF INJUR			-	1 -	POLITION (Street a	Step		outo Alumbas
	4 Homicide 8 Could not be	building, atc. (Spe	icify)				City or Town, State)			
<u> </u>	29a. CERTIFIER	English					Salisbur			Tand
릴	(Check only	ICIAN: To the beat of my know								
COMPLET	2 X MEDICAL EXAMIN	ER: On the basis of examination	on and/or investigation	on, in my opinie	on, death occured a	it The Jim	ne, data and place, an	d dua lo th	e cause(a)	and menner ea stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIE	P P			29c. LICENSE	NUMB	ER	29d. DAT	E SIGNED	(Month, Day, Year)
0 8	John 5 G	Sulkeley	gim.	D.M.	E DOS	359	9	0	2-17	'- 95
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Type	, Print)	-					
	John T. Bulkel	ev.M.D. 1	08 Pine	Bluf	f Road	, S.	alisbury	7, M	D 21	.801
	31. DATE FILED (AA) 17. 201 1095	FILL DUNG	NATURE							
	L LD 61 1393	Java a ways	- Wardall)



D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. WPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

			1	-			95	07915	
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)		M-,114	1.3		2. DATE OF DEATH	W y	3. TIME OF DEATH	
	RUTH E.		Mulli yrs. lest birthday)	KIN IF UNDER 1 YEAR	IF UNDER 24 HRS.	February	La	95 6:15 P M	
		¹□ M 2XX 87	87 YRS. MONTHS DAYS HOURS MIN. APR.				23,1907 MARYLAND		
DIRECTOR	MEMORIAL HOSPI				STON	DEATH		ALBOT	
3EC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY	
	MARYLAND TALB	OT		EASTO				1 X YES 2 NO	
FUNERAL	201 FEDERAL ST.			16	7. ZIP CODE 21601	L	USA	N OF WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 1 YES IF YES, GIVE WAR OR DATE	XXNO	13. WAS DEC If yes, sp 1 YES	CENDENT OF HISPA pecify Cuban, Mexic 3 2 NO Speci	NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.)	or No.— 14	Black, White, etc. Specify: WHITE	
	15. DECEDENT'S EDUCAT (Specify only highest grade col		6e. DECEDENT'S	USUAL OCCUPATI	ON ost of working	16b. KIND OF BUS	INESS/INDUS	TRY	
COMPLETED	11	College (1-4 or 5 +) -0-	life. Do NOT us	se retired.)	CEPTION	NIST FU	NERAL	номе	
	17. FATHER'S NAME (First, Middle, Last) JOHN POOLE				The state of the s	AME (First, Middle, Maiden ZABETH MY			
BE	19+. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or Town		odel	
2	MARIAN B. TRIPP	E				ASTON, MD			
	20e. METHOD OF DISPOSITION 1X Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State 20b.Pt	RING F	OF DISPOSITION (Nather place)	eme of	2-27 EAS	TON,	y or Town, State MD 21601	
	21. SIGNATURE OF FUNERALS SERVICE LICEN		FSF	NEWN	ND ADDRESS OF FA	ERAL HOME	, P.A	١.	
	IN TO VOLUM	1au	7. L 21	200			. EAS	TON. MD	
	23. PART I. Enter the diseases, or con ahock, or heert failure. Lis IMMEDIATE CAUSE (Finel disease or condition resulting in death)	mplications that ceused the st only one ceuse on each	he death. Do r	not enter the mo	S. HARI	RISON ST.	retory arreet	t, Approximate Interval Between Onset and Death	
ERTIFICATION	anock, or neert failure. Lis IMMEDIATE CAUSE (Finel disease or condition	mplications that ceused the st only one ceuse on each	onsequence of	not enter the mo	S. HARI	RISON ST.	retory arreet	t, Approximate Interval Between Onset and Death	
0	shock, or heer tellure. Lis IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF	P:	S. HARI ode of dying, such believe tria, B	rison st.	gs	t, Approximate interval Between Onset and Death Uncertain	
0	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR AS A CO	onsequence of on	P:	S. HARI ode of dying, such believe tria, B	rison st.	AUTOPSY MED?	t, Approximate Interval Between Onset and Death	
MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inlitered events resulting in death) LAST PART II. Other significent conditions of	DUE TO (OR AS A CO	ONSEQUENCE OF	P:	S. HARI Bode of dying, suc Bodis Grant Strike Grant St	RISON ST. ch as cerdlec or respiration of the Legister of the	AUTOPSY MED?	t, Approximate Interval Between Onset and Death Uncertain Lancertain 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST PART II. Other aignificent conditions of the conditions of the cause o	DUE TO (OR AS A CO	onsequence of the resulting of the second of	P:	S. HARI pode of dying, suc tia. S g ceuse given in	RISON ST. ch as cerdlec or respiration of the Legister of the	AUTOPSY MED?	t, Approximate Interval Between Onset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
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MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST PART II. Other aignificent conditions of the conditions of th	DUE TO (OR AS A CO	ONSEQUENCE OF DEATH YE PLACE OF DEATH DEATH YE PLACE OF DEATH ONSEQUEN	In the underlyin TH (Check only one) OTHER: 4 Nursing Hom	S. HARI pode of dylng, suc tria g ceuse given in	RISON ST. ch as cerdiec or respiration of the learning of the	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO	
PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST PART II. Other aignificent conditions of the conditions of th	DUE TO (OR AS A CO DUE TO (OR AS	ONSEQUENCE OF THE PLACE OF DEATH YE PLACE OF DEATH INJ	In the underlying the first the underlying the unde	S. HARI Dide of dying, such Comparison Grant	RISON ST. ch as cerdiec or respiration. Part I. 24a. WAS AN PERFOR 1 YES 2	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST PART II. Other aignificent conditions of the cause cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST DID TOBACCO USE CONTRIBUTED TO MEDICAL EXAMINER? 1 YES 2 NO H	DUE TO (OR AS A CO	ONSEQUENCE OF DEATH YE PLACE OF DEATH INJ	In the underlying the first the underlying the unde	S. HARI Dide of dying, such Comparison Grant	RISON ST. ch as cerdiec or respiration of the learning of the	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO	
BY PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 Y NO 1 Netural 5 Pending Investigation 1 Suicide 6 Could not be determined 29e. CERTIFIER (Check only)	DUE TO (OR AS A CO DUE TO (OR AS	ONSEQUENCE OF DEATH YE PLACE OF DEATH INJ	In the underlying the following the first the underlying the underlying	S. HARI pode of dying, suc Colored to the colored	Part I. 24a. WAS AN PERFOR 1 YES 2 O ther (Specify) 28d. DESCRIBE HOW IN City or Town, Stete)	AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO	

296. SIGNATURE AND TITLE OF CERTIFIER
ROBert W Treven, M.D. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D10938 2 -24-95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ER, M.D., 7696 OCEAN GATEWAY, EASTON, MD 21601 ROBERT W. TR
31. DATE FILED (Month, Day, Year)
FEB 2 7 1995 TREVER,

98.78.44

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after de	
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Merlyn K.

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31. DATE FILED (Month, Day, 1987)
MAR 02 1995

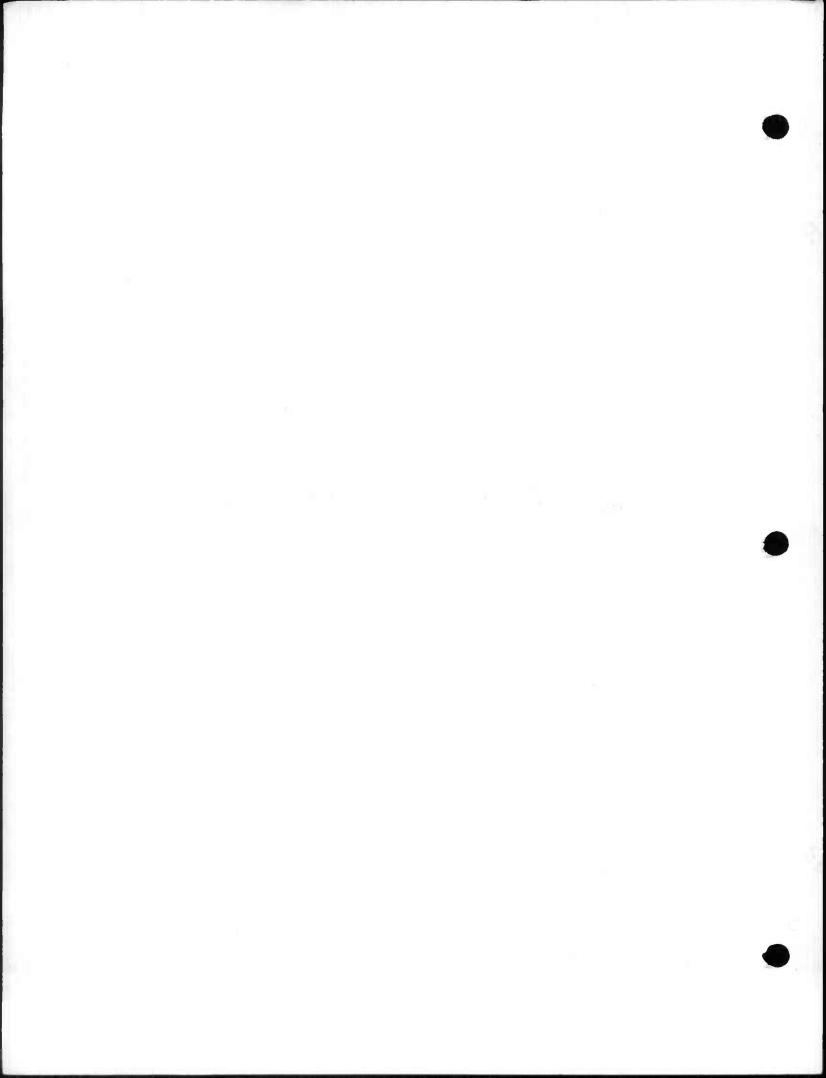
M.D.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24/10/us after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

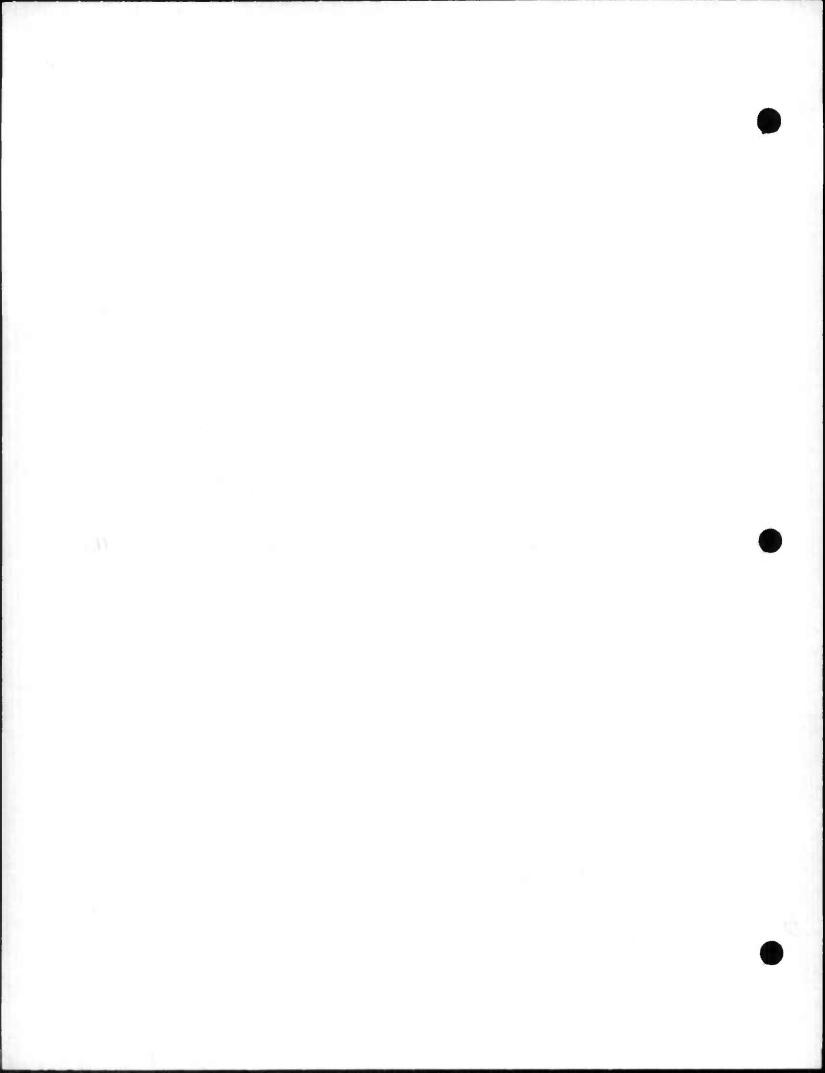
	FOR 1 STATE	STATE OF M	ARYLAND /	DEPAR	TMENT	OF H	EALTH	AND I	MENTAL HYGI	FNF			
	1 - STATE REGISTRAR	100			ICATE				REG.				
1	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATN	
	Mae Jos	sephine		N	lanog	ne			Feb.	22	1995	SY 450.	М
- 1		. SEX	8. AGE (In yrs. lest		IF UNDER	1 YEAR	IF UNDER		7. DATE OF BIRTN		8. BIRTI	NPLACE (State or Foreign	
	579-60-0832	☐ M 2 🔀 F	100	YRS.	MONTHS	DAYS	HOURS	MIN.	June 13,		Count	sh.,D.C.	
	9a. FACILITY NAME (If not institution, give street	t and number)			9b. CITY,	TOWN O	R LOCATIO	ON OF DE			UNTY OF D		
DIRECTOR	Fernwood Nursing Ho				Bethesda					Montgomery			
E	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OF	R LOCAT	ION					10d. INSIDE CITY	
FIG	none no	one		Wa	shing	ton	- D.	C.				LIMITS?	
	10e. STREET AND NUMBER				0	_	ZIP CODE			18g, Cl	TIZEN OF V	WHAT COUNTRY?	_
FUNERAL	4000 Massachusetts						200	16		Ţ	J.S.A		
2	11. MARITAL STATUS 12 1 Never Married 2 Married	2. WAS DECEDENT FORCES? 1	EVER IN U.S. ARN		13. W	AS DECI	ENDENT OF	F HISPAN	IC ORIGIN? (Specify In, Puerto Rican, etc.)	Yee or No-	14. RACI	E American Indian, k. White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WA					2 ⊠ NO				Spec		
											l w	hite	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION npleted)	(G/v	e kind of y	USUAL OC	CUPATIO uring mos	N st of working	9	16b. KIND OF	BUSINESS/IN	OUSTRY		
3	Elementary/Secondary (0-12)	College (1-4 or 5+)	III III	Do NOT us									ì
M	12			hou	sewif	e				vn hor			
E CO	17. FATHER'S NAME (First, Middle, Last) William H. Manogue								ME (First, Middle, Mak				
00	19e. INFORMANT'S NAME (Type/Print)	:	19h	MAILING	ADDRESS	(Street n			beth C. 1				-
2	Elizabeth Malonev								y Chase,				
	20e. METHOD OF DISPOSITION		20b. PLACE AI					JIIC V	DATE 20c.				-
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	t from State	cemetery, crem	natory or o	ther place)	110.1	no o.		2/25		,		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	TML. UI	ive	22. N	AME AN	D ADDRES	S OF FA	CILITY DeVol	Was	sh.,	D.C.	
	· ames &	29/			222	22 W	iscor	nsin	Ave. NW	Wash.	D.C.	20007	
	23. PART . Enter the diseases, or com	plications that	caused the dea	th. Do r	ot enter t	the mod	de of dylr	ng, sucl	h aa cerdiec or re	apiratory a	rreat,	Approximata	
	anock, or neart failure. List	t Dnly one caus	e on each line.									Interval Between Onset and Death	
	disease or condition	MYO C	audia	/	//	nf	VAIT	ho					1
	resulting in death) a	DUE TO (OR AS A CONSECU	UENCE O	F):	1/6	ouc,	101	/				-
z	MATERIAL SILVER											Ì	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (C	OR AS A CONSECU	UENCE OF	7):								_
3	cause. Enter UNDERLYING CAUSE (Disease or Injury											Į	
Ē	that initiated events	DUE TO (C	OR AS A CONSEQU	UENCE OF	F):								_
E	resulting in death) LAST											ļ	
- 1	DADT II Other classificant and this			4									
3	PART II. Other aignificent conditions of		eath but not re	aulting	n the und	derlying	ceuse gi	iven in		AN AUTOPSY ORMED?	24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	8
ă		scu/us	////	u	1610	ne	4		1 YES	2 NO		COMPLETION DF CAUSE OF DEATH?	
Σ	Dementia.						<u>(</u>		_			1 YES 2 NO	
ä													
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:			OTHER		ACE OF DE	ATH (Che	eck only one)				
YS!		☐ Inpetient 2 ☐ i	ER/Outpatient 3	DOA	4 X Nursi		5 Res	sidence	a Other (Specify)				
PHYSICIAN: MEDICAL	27, MANNER OF DEATH	28a. DATE OF III		28b. TIM	E OF 2	28c. INJL WOF			28d. DESCRIBE NO	W INJURY O	CCURED	-	1
B	1 Natural 5 Pending 2 Accident Investigation				М		ES 2 🗌	NO					1
(1)	3 Suicide a Could not be	28e. PLACE OF building, et	INJURY — At hom	ne, term, s	treet, factor	ry, office			28f. LOCATION (Stre City or Town, St.	et end Numbe	er or Rural F	Route Number,	1
	4 Homicide determined		(-)						ony or rown, on	110)			ı
٦ ا	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN	N: To the best of m	ry knowledge, des	th occurre	d at the tim	ne, data	end place,	and due	to the cause(e) and	nanner ee st	ated.		٦
COMPLETED	one) 2 MEDICAL EXAMINER: 0) and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	111					29c. LICE						4
8	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	1/0	MILL	112	MI) h	296. LICE 03579		RDCR .			(Month, Day, Year)	
일	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE	OF DEATH (ITEM	20/2500	Dried)	<u> </u>		. T		-re	D., Z.	3, 1995	4

9801 Georgia



CALLIMONE, MANITAND 21213
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attends
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as a
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

						95	07917
	1 - STATE OF MARYLAN		TMENT OF I		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) Kenneth Mic	hael N	Morgan		2. DATE OF DEATH	AY OOF YE	3. TIME OF DEATN
		rs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	March 1,	1995	6:55 A M
	074-48-0235 1 M 2 F 40	YRS.	MONTHS DAYS	HOURS MIN.	July 15,	1954	New York
TOR	14800 4th Street, #90A		Laure	OR LOCATION OF DI	EATH	Prince	e George's
DIRECTOR	Maryland Prince George's		r, town or Loca Laurel	TION	1		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
IA!	10e. STREET AND NUMBER		10	f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	14800 4th Street, #90A			20707			d States
5	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U. FORCES? 1) YES 15. YES, GIVE WAR OR DATE	S. ARMED	If yes, s	pecify Cuben, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No 14. I	RACE — American Indian, Black, Whita, atc.
B 4	3 Wildowed 4 Divorced Vietnam era	S		sı⊒ No spec# Osta Rica			specify: Black
TED	(Specify only highest grade completed)	(Give kind of a life. Do NOT us	USUAL OCCUPATI york done during me e mtimd.)	ON ost of working	16b, KIND OF BU		
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) 12		ŕ	e Assista	Dept. o int Law Fir		/
	17. FATHER'S NAME (First, Middle, Leat) David Morgan			18. MOTNER'S NA	ME (First, Middle, Maiden		
) BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAJLING	ADDRESS (Street		rie Haynes Route Number, City or Tow		0)
12	Gregory R. Pease	4630			, Washing	ton, D	C 20017
	20b. PL 1 □ Burtel 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ACE AND DATE (per place) Ke Crema	at orv		tevill	or Town, State e, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	lesapea	22. NAME A	ND ADDRESS OF FA	CILITY		e, Maryiana
	Deen H. Rap.	P	933 G	ist Aven	Services, ∪e, Silver	Spring	, MD 20910
	23. PART I. Enter the diseases, or complications that caused the ahock, or heart failure. List only one ceuse on each IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or AS A CC	ilne. n musi	defu		man cerdiac or respi		Approximate interval Between Onset and Death
NO O	Sequentially list conditions		/	11			
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	INSECUENCE OF	7):				
TIFI	that initiated events DUE TO (OR AS A CO resulting in death) LAST	NSEQUENCE OF):				
B	d						
PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to deeth but	not recuiting i	n the underlyin	g ceuse given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
P P					I _ YES 2	X NO	OF DEATN?
N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF I	DEATH YE	S NO C	UNCERTAIN	V 🗆		1 TES 2 NO
S	EXAMINER? HOSPITAL:	T	N (Check only one) OTHER:				
HYS	1 YES 2 NO 1 Inpetient 2 ER/Outpetie	M 3 DOA		ne 5 X Residence	6 Other (Specify) 28d. DESCRIBE NOW II	HIEV OCCUPE	
ВУ Р	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJ	JRY WO	PRK? YES 2 NO	and Describe How I	SORT OCCORE	
COMPLETED	3 Suicide 6 Could not be determined 28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, s	treet, factory, offic		281. LOCATION (Street a City or Town, State)	nd Number or Ru	iral Route Number,
IPLE	29a. CERTIFIER (Check only CERTIFYINO PNYSICIAN: To the best of my knowledge						
CO	one) 2 X MEDICAL EXAMINER: On the basis of examination en	d/or investigation	n, in my opinion, d	leath occured at the	lime, date and place, an	d dua lo lhe cau	rse(a) and manner as stated.
TO BE	Tugasto Hoday ux Mi	1	<i>J</i>	DICENSE NUN	BER 30		NED (Month, Day, Year) ch 1, 1995
		009 Ray		urt, Cam	p Springs,	MD 20	748-2230
	MAR 02 1995 32. RICHSTRAMS SIGNATU	Revolate					



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	1 - STATE REGISTRAR	SIMIE UP N	MARYLAND (DEPAI ERTIF	RTMENT (OF H OF	IEALTH AND DEATH	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH	0.	3	. TIME OF DEATH
		Herman	Michael	Mc	Lennor	1		February	²⁵ .]	.995	12:50 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la:		IF UNDER 1 1		IF UNDER 24 HRS	7. DATE OF BIRTH	20, 1		ACE (State or Foreign
	711-10-8467	1 🕅 M 2 🗆 F	92	YRS.	MONTHS E	DAYB	HOURS MIN.		1902	Country)	
	9a. FACILITY NAME (If not institution, give st	reet and number)	0		9b. CITY, T	DWH C	R LOCATION OF			SOUTE STY OF DEA	Carolina
DIRECTOR	Magnolia Gardens Nursi	ng & Rehab:	ilitation	Ctr	Lanh	nam			Pri	nce 6	George's
[[[RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			100 CIT	Y, TOWN OR	LOCAT	TON				
E I	Maryland Princ	ce George	10		anham	LOGA	ion				Dd. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	ocorge	, 3		allialli	101	. ZIP CODE		10+ CITI		YES 2 X NO
8	8613 Seasons Way					100	20706-3	900			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN			13. WA			PANIC ORIGIN? (Specify 1			tates - American Indian,
	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	TYES 2 X	NO	lf y	es, spe	ecify Cuban, Max 2 ☑ NO Spe	ican, Puarto Rican, etc.)		Black, V Specify:	White, etc.
BY	3 Wildowed 4 XXVDivorced				_ ''		a po no ope	cay.		Bla	ck
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		16a. De	CEDENT'S	USUAL OCCI	UPATIC	ON st of working	16b. KIND OF E	USINESS/IND		
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+	Eld.	. Do NOT u	se retired.)			1			
M M	10		C	hef				Navy (Depart	ment	
	17. FATHER'S NAME (First, Middle, Last)	_					ISSUETATION I	NAME (First, Middle, Maid			
BE	William Buchanar	1	1				Carri			_	
2	R. Sandra McLenn	OD	19				nd Number or Rui	al Route Number, City or To	own, State, Zip	Code)	
		000 00 20									
	20a. METHOD OF DISPOSITION 1	oval from State	cemetery, cre	emetory or g	ther place)			1			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	- I tries	apear	ce Cre		DOTY D ADDRESS OF	2-28 Be	LUSVII	те, м	aryıand
	· Soria.t	door	moi		Ra 93	3 G	Funeral Sist Ave	l Services, enue. Silve	er Spr	ing.	MD 20910
	23. PART I. Enter the disease, or cahock, or heert failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	omplications their let only one cau	t coused the dese on each line	beth. Do	A P	20	de of dylng, a	te de cardiec or ree	piratory arr	est,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
MEDICAL C	PART II. Other algnificent conditions	contributing to	deethyout not i	anc	in the unde	M	SCLO)		N AUTOPSY DRMED?	AV	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S NO	0 🗆	UNCERTA	IN 🗆		1	YES 2 NO
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check onl)	y one)					
Š	1 TYES 2 XNO	1 Inpatient 2	ER/Outpetient 3	□ DOA	OTHER:	g Home	5 🗆 Realdenc	a 6 Other (Specify)			
Y PHYSICIAN:	27. MANNER OF DEATH 1 X Netural 5 Pending Investigation	26a. DATE OF (Month, Da		28b. TIM	URY	WOI	URY AT RK? ES 2 NO	28d. DEŞCRIBE HOW	INJURY OCC	URED	
TED BY	2 Accident investigation 3 Suicide 6 Could not be determined	26s. PLACE Of building,	F INJURY — At ho etc. (Specify)	me, farm,	streel, factory	, offica		281. LOCATION (Street City or Town, Steel	t and Number e)	or Rural Rout	te Number,
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER							٠, ,			nd menner as stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1	111	1	1//	2	29c. LICENSE N	UMBER 1274			onth, Day, Year) / 27, 1995

Essam Tellawi, M. D., 7700 Old Branch Avenue, #B-102, Clinton, MD 20735-1629

31. DATE FILED (Month, Dev. Vent)

FFR 28 1995

32. REGISTRAR'S SIGNATURE

This divides Result

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permit. Pages 1, 2, 3 should

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e retained by the hospital or attending physician.	or, page 5 should be detached for use as the burial-transit		notified at once.
6 may b	ed in by the funeral director, pag-		Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notifie
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equires that the death cer	e atte	Aental	uny, c
hat the	d by th	and A	ny in
uires t	certificate has been signed by the att	nours after death with the State Dept. of Health a	IN'S a
W req	been:	pt. of	3 she
The	ate has	ate De	еш 2
CIAN	ertifica	the St	10
PHYS	ter this cer	with	rrked,
DING	: After	death	is ma
TE	CTOR	after	28
OR O	DIRE	hours after deat	Item

Amended #195 #22 2/28/95 MRT Montgor 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Gary Catterton MYERS February 1995 6:00 a M 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH
March 14,1929 8. BIRTHPLACE (State or Foreign 213-24-2960 XX M 2 D F 65 DAYS Maryland YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Doctor's Community Hospital Lanham Prince George's DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Greenbelt 1XXYES 2 NO 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 11-F Ridge Road 20770 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No if yes, specify Cuban, Maxican, Puarto Rican, stc.) 14. RACE — American Indian, Black, White, atc. FORCES? XX YES 2 NO 1 Never Married 2 XXMarried 1 TES 2 X NO Specify: BY Specify: White 3 Widowed 4 Divorced 1951 - 1953 G 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade of COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Service Technician 12 Telephone Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Tillman Myers Edith Catterton BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code). 2 Ruth Adele Myers same as #1 10 20. METHOD OF DISPOSITION
1 X Aurisi 2 Cremation 3 Removel from State
4 Donemon 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Greenbelt City Ommetery February 28,1995 Greenbelt, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Milel Road Beltsville, Md. 20705 23. PART 1. Enter the diseases, or compileations that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory failure
DUE TO (OH AS A CONSEQUENCE OF):

Carino Ma of the Lung **IMMEDIATE CAUSE (Final** Onset and Death disease or condition_ 424 hrs resulting in death) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL fibrillation 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 12 Natural 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide DELCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D37934 February 25, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephenie Trifoglio, MD 7500 Greenway Contambile Greenbed-AD 20770 32 REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

578-50-5233

Joseph W. Maquire, Jr

5. SEX

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Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH DIRECTOR 18428 Bishopstone Court Gaithersburg RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Maryland Gaithersburg Montgomery permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE burial-transit 18428 Bishopstone Court 20879 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexicen, Puerto Rican, etc.) FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 X Merried 1 TYES 2 NO B Specify n by the funeral director, page 5 should be detached for use as the removal. 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co (Give kind of work done life. Do NOT use retired.) ET Elementary/Secondary (0-12) College (1-4 or 5 a) COMPL 4 Owner Mortgage Banking once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme, notified at Joseph W. Maguire, Sr. BE Mary Elizabeth McDonald 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Elizabeth A. Maguire 18428 Bishopstone Court, Gaithersburg, MD è 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 🕅 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of commetery, crematory or other place) February 27, 1 Montgomery Crematorium, Inc. 20c. LOCATION -- City or Town, State must 1995 4 Donation 5 Other (Specify) Bethesda, Maryland 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery
Avenue, Rockville, Maryland 20850-2805 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00831 Darbara Whence medical 23. PART I. Enter the disea ses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, completely filled in by rial, cremation, or remo shock, or heart fallure. List only one cause on each line. **IMMEDIATE CAUSE (Fine)** the disease or condition BUE TO (OR AS A CONSEQUENCE OF): resulting in death) event. bunal, traumatic CERTIFICATION and Sequentially list conditions, prior to the attending physician Mental Hygiene prior to if any, leeding to immediate cause. Enter UNDERLYING other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in deeth) LAST 6 injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL this certificate has been signed by a with the State Dept. of Health and shows any 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 🕅 Residence 6 🗆 Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 1 Natural 5 Pending Investigation L DIRECTOR: After the hours after death v 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 28 4 Homicide 29e. CERTIFIER
1 1 🖔 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner ee stated. TO THE HOSPITAL OF TO THE FUNERAL OF THE MITTIN 72 IN IMPORTANT: If It (Check only one) 2 __ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Meultare D31391 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suhair Abulfarag, M.D. 19261 Montgomery Village Avenue, #Q-10, Gaithersburg, MD 31. DATE FILED (Month, Day, Year)
FFR 28 1995 3. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS

HOURS

6. AGE (in yrs. last birthday)

55

VDQ

95 07920

YEAR

1995

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

Specify

United States

14. RACE — American Indian, Black, White, etc.

3. TIME OF DEATH

5:45

10d. INSIDE CITY

1 X YES 2 NO

White

20879

Approximeta

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TES 2 NO

29d, DATE SIGNED (Month, Day, Year)

February 27, 1995

Interval Between

Onset and Death

earl

8. BIRTHPLACE (State or Foreign

Virginia

PM

REG NO

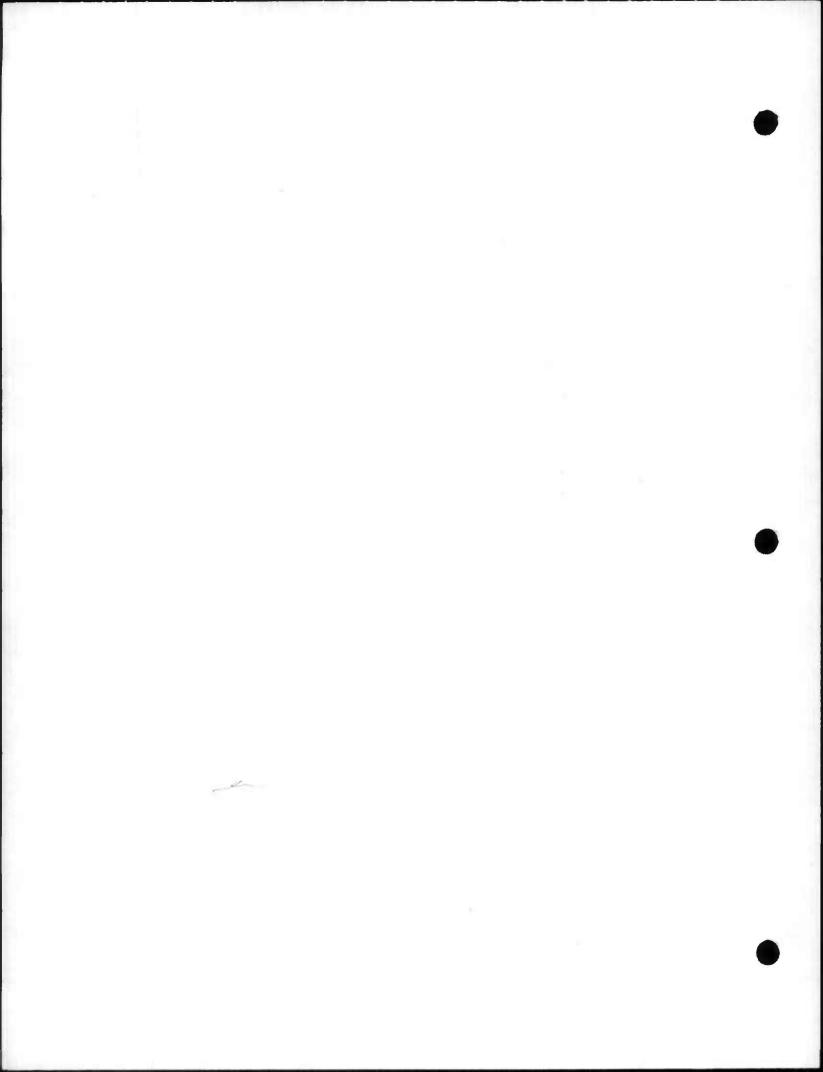
25,

2. DATE OF DEATH

February

7. DATE OF BIRTH (Month, Day, Yea

Sept. 8, 1939



95 0792 County Amended # 17 2/24/95 MRT Montgomery

1 - STATE
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

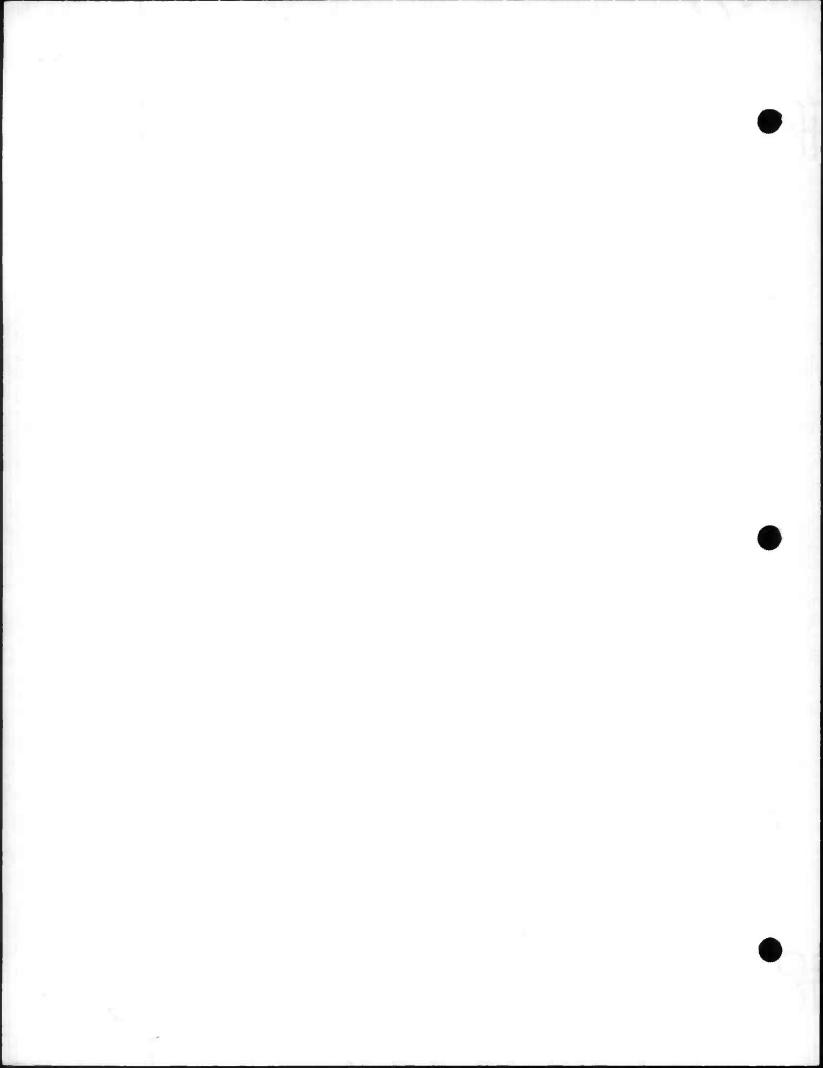
	HEGISTRAH		CEN	III IUA	IL OF	DEATH	-	REG. NO.		
	1. DECEDENT'S NAME (First, Middle Last)	ERES,	1 in	110	0	HV	2. DATE O	DV		YEAR 3. TIME OF DEATH
				4K	1-1	17	FE	3 2	2 19	795 5:10 H
			GE (In yrs. lest birt	hday) IF UN	DER 1 YEAR	IF UNDER 24 HRS		P BIRTH Day, Year)		8. BIRTHPLACE (State or Foreign Country)
	577 05 5012	1 M 2 5 F	84 Y	RS.	DATS	HOURS MIN.	Nov.		910	Washington D.C.
~	9a. FACILITY NAME (If not institution, give street			96. C		OR LOCATION OF	DEATH			NTY OF DEATH
DIRECTOR	8301 Ashford Blvd.	Apt. /19			La	urel			Prin	ice Georges
ដ្ឋា	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10	c. CITY, TOW	N OR LOCAT	ION				10d. INSIDE CITY
뜸	Maryland Prince	Georges	1	Lau	-					LIMITS?
	10a. STREET AND NUMBER				10	I. ZIP CODE			10a CITI	1 X YES 2 NO ZEN OF WHAT COUNTRY?
FUNERAL	8301 Ashford Blvd.	Apt. 719			1	2070	7		100.011	USA
S		12. WAS DECEDENT EV			13. WAS DEC	ENDENT OF HISP	ANIC ORIGIN?	(Specify Yes	or No.	14. RACE — American Indian.
	1 Never Married 2 Married	FORCES? 1 1				ecify Cuban, Max 2 X NO Spe		ean, etc.)		14. RACE — American Indian, Black, White, etc. Specify: White
В	3 Wildowed 4 Divorced					- <u>Al</u> opc	,			WIIILE
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION impleted)	18e. DECEDI	nd of work do	ne durina mo	ON st of working	16b, I	IND OF BUS	INESS/IND	USTRY
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do l	VOT use retire	d.)					
₽ P	12		Clerk	Тур	ıst			abor 1		1
	17. FATHER'S NAME (First, Middle, Last)	1				18. MOTHER'S		idle, Maiden	Sumame)	
H	John Murophy Muri	ony					Wright			
2	19a. INFORMANT'S NAME (Type/Print) Margaret Dillman	,				and Number or Run				
					-	Court		-		
	20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Remove	al from State	20b. PLACE AND I cemetery, cremator	ne or other ole	col		DATE			City or Town, State
	4 Donation 5 Other (Specify)	ISEE	Fort Li			tery 2		Brei	itwoo	d, Maryland
		010	/ /					Fune	ral H	lome, Inc.
	Limothys	y. Can	stell		500 U	niversi	ty Blv	d.W.	Sil.S	Spr.,MD 20901
	23. PART I. Enter the diseases, or con ahock, or heart feliure. List IMMEDIATE CAUSE (Fine) disease or condition	mplications that cause of	on each line.							intervei Between Onset and Death
	resulting In death)	DUE TO (OR	AS A CONSEQUEN	CE OF):	Ca	rdio"	vase	ul	No	disease
z	and the residence of the second secon									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEQUEN	CE OF):						
2	cause. Enter UNDERLYING CAUSE (Disease or injury									
	thet initiated events	DUE TO (OR	AS A CONSEQUEN	CE OF):						
H	d.									
	PART II. Other significent conditions	contributing to dea	th but not resul	ting in the	underlying	g cause given	n Part I. 2	4a. WAS AN		24b. WERE AUTOPSY FINDINGS
EDICAL								PERFOR		AVAILABLE PRIOR TO COMPLETION DF CAUSE
									X	DF DEATH?
Σ.	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH	YES 5	KNO F	UNCERTA	JN \square			10,100
¥.	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF							
8 1		IOSP1TAL:	Outpatient 3 🗆 D	OA 4 1	ER: Nursing Hom	e 5 Realdenc	8 🗆 Other (Specify)		
S		28a. DATE OF INJU		. TIME OF	28c. INJ	URY AT	_	RIBE HOW IN	JURY OCC	CURED
HYS	27. MANNER OF DEATH		ar)	INJURY		RK? (ES 2 ND				
Y PHYSICIAN:	1 Netural 5 Pending	(Month, Day, Ye			I	_				
B	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	(Month, Day, Ye	URY — A1 home, f	erm, street, t			28f. LOCAT	ION (Street a	nd Number	or Rural Route Number,
B	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Ye	URY — A1 home, f Specify)	erm, street, i			28f. LOCAT City or	ION (Street a Town, State)	nd Number	or Rural Route Number,
B	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined	(Month, Day, Ye 28a. PLACE OF INJ building, atc. (Specify)		actory, office		City or	Town, State)		
B	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only)	(Month, Day, Ye 28a. PLACE OF IN) building, atc. (Specify)	ccurred at th	actory, office	and place, and d	City or	Town, State)	ner as state	pd,
COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only)	(Month, Day, Ye 28a. PLACE OF IN) building, atc. (Specify)	ccurred at th	actory, office	and place, and d	City or	Town, State)	ner as state	ed, e cause(a) and manner as stated.
BE COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be distarmined 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER:	(Month, Day, Ye 28a. PLACE OF IN) building, atc. (Specify)	ccurred at th	actory, office	and place, and d	City or	Town, State)	ner as state	pd,
E COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	(Month, Day, Ye 28a. PLACE OF IN) building, atc. (nowledge, death o atlon and/or invest	ccurred at th	actory, office	and place, and d	city or use to the cause to the	Town, State)	nor as stated due to the	ed, e cause(a) and manner as stated. E SIGNED (Month, Day, Year) EL 23, 1995
BE COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	(Month, Day, Ye 28e. PLACE OF INI building, atc. (AN: To the best of my k On the best of examin	nowledge, death o atlon and/or invest	ccurred at th	actory, office the time, data by opinion, d	and place, and death occured at 11 29c. LICENSE N	city or use to the cause to the	Town, State)	nor as stated due to the	ed, e cause(a) and manner as stated. E SIGNED (Month, Day, Year) EL 23, 1995
BE COMPLETED BY	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	(Month, Day, Ye 28e. PLACE OF INI building, atc. (AN: To the best of my k On the best of examin	nowledge, death o ation and/or investor and/or	ccurred at th	actory, office	and place, and death occured at 11 29c. LICENSE N	city or use to the cause to the	Town, State)	nor as stated due to the	ed, e cause(a) and manner as stated. E SIGNED (Month, Day, Year) EL 23, 1995

DIVISION OF VITAL RECORDS. P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hors after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL O	THE FUNERAL DI	PORTANT: If ite

_	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H	IYGIENE
_	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

		1 - STATE REGISTRAR				CERTIE	CATE	OF DEA	TH	MENTAL I				
		1. DECEDENT'S NAME (First, Middle, L	est)			CLRIII	ICAIL	OF DEA	In	2. DATE OF	REG. NO).		
		ELSIE EVELYN MO		N						MONTH	0	AY .	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		SEX	8 AGE //c	r yrs. last birthday)	IF UNDER 1	read I recomme	R 24 HRS.	Febru		25, .		6:45 AM
1		510017971		□ M 2 🕅 F	or riot (m			AYS HOURS	MIN.	(Month, D	my, Your)		Count	
		9a. FACILITY NAME (If not institution, g				81 YRS.				Aug.	18,			ahoma
00	.			and number)				OWN OR LOCAT		EATH		9c. COL	JNTY OF D	DEATH
2		1712 Maydale Dr	ive				Silv	er Spr	ing			Moï	atgor	ery
DIRECTOR		10e. STATE 10b. CO				10c. CIT	Y, TOWN OR	LOCATION						10d. INSIDE CITY
		Marvland Mon	i gor	mery		- 1	ver S							LIMITS?
		10a. STREET AND NUMBER				1 52.		101. ZIP COC	NE.		_	100 00	TIZEN OF Y	1 KKyes 2 No
BY FUNERAL		1712 Maydale Dr	1370					2090						
=		11. MARITAL STATUS		. WAS DECEDEN	T EVER IN	IIS ADMEO	T 42 W	S DECENDENT		NO OBIONO M				States
Ī		1 Never Married 2 Merried		FORCES? 1 IF YES, GIVE W	YES	2 NO	lf y	es, specity Cubi	en, Mexica	n, Puerto Rica	n, etc.)	or No-	Black	E — American Indien, k, White, atc.
≽	i	3 Widowed 4 Divorced		IF YES, GIVE W	MH OH DAI	IES	1 1	YES 2 [NO	Specify	y:			Spec	White
		15. DECEDENT'S				16a. DECEDENT'S				16b. KII	ND OF BU	SINESS/IN	DUSTRY	MILLEC
1 1		(Specify only highest g Elementary/Secondary (0-12)		ollege (1-4 or 5 +	,	(Give kind of life. Do NOT u	work done dur se retired.)	ng most of work	ng					
. 로		12				Clerk				Por	wer !	Utili	ity I	ndustry
COMPLETED		17. FATHER'S NAME (First, Middle, Last))					1a. MOT	HER'S NA	ME (First, Midd				
TO BE COM		John B. Smith								Bridge				
BE		19e. INFORMANT'S NAME (Type/Print)	-			19b. MAILING	ADDRESS (S	treet and Numbe		_		n. State. Zi	in Code)	
2		Jack E. Morton												and 20905
3	I	20a. METHOD OF DISPOSITION			20b. F	PLACE AND DATE			,	DATE	7		City or To	
2		1 Buriel 2 CCremation 3 F 4 Donation 5 Other (Specify)	levomef	from State	ceme	tery, crematory or o	ther niece)		7	1				aryland
	1	21. SIGNATURE FUNERAL SERVICE	Licend	fee ,	0	LE MAINE		ME AND ADDRE		CILITY	DIE	TEWOC	Ju, P	aryranu
	ı	1 / 5	/	-H			Hin	es-Rina	aldi	Funera	al Ho	ome,	Inc.	
	4	spoken,	12	who	4	100	118	00 New	Hamp	shire	Ave.	. Si	lver	Spring, MD
; `	7	23. PART t. Enter the diseases, ahock, or heart falls	o com	plicetions that	coused	the death. Do	not enter th	e mode of dy	ing, auci	h an cardiac	or reap	ratory ar	rreat,	Approximata Interval Between
5	H	IMMEDIATE CAUSE (Finel												Onset and Death
		disease or condition reaulting in death)	a.	E	upp.	Isrma								5yR.
				DUE TO	(OR AS A	CONSEQUENCE O	F):							
Z	. 11													1
	. 11	Sequentially list conditions	b											
I E		Sequantially list conditions, if any, leading to immediate	b	DUE TO	(OR AS A (CONSEQUENCE O	F):							
ICATIC		If any, landing to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b											
TIFICATIC		If any, landing to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b			CONSEQUENCE O								
ERTIFICATION		If any, landing to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b c d											
L CERTIFICATION		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b c d	DUE TO	(OR AS A C	CONSEQUENCE O	F):	rlying cause	given in	Part I. 24	n, WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
CAL		If any, landing to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	d	DUE TO	(OR AS A C	CONSEQUENCE O	F):	rlying cause	given in		PERFOR	RMED?	24b.	AVAILABLE PRIOR TO
CAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cd	DUE TO	(OR AS A C	CONSEQUENCE O	F):	rlying cause	given in			RMED?	24b.	
MEDICAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions to the cause of the cau		DUE TO	(OR AS A C	CONSEQUENCE O	in the unde	·		11	PERFOR	RMED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions to the condition of the condition of the cause of	NTRIB	DUE TO	death bu	t not resulting	in the unde	D UNC		11	PERFOR	RMED?	246.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions to the condition of the condi	NTRIB	DUE TO CAL	death bu	t not resulting DEATH YE	in the unde	D UNO	CERTAIN	N 🗆	PERFOR	RMED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions to the condition of the condi	NTRIB	DUE TO DON'T IN THE TO CA	death bu	t not resulting DEATH YE	in the under	UN(CERTAIN	1 1 6 Other (Sp	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions to the condition of the condi	NTRIB	DUE TO CAL	USE OF	t not resulting DEATH YE B. PLACE OF DEATH There is a DOA 26b. TIM	in the under the	UNC one) Home 5 PR I Home 5 PR	CERTAIN	N 🗆	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions of the condition of the condition of the condition of the condition of the condition of the cause of	NTRIB	DUE TO DUE TO DUE TO CA	USE OF	t not resulting DEATH YE PLACE OF DEATH THENT 3 DOA 26b. TIM	in the under the	UNC One) Home 5 PR WORK? YES 2	CERTAIN	6 Other (S)	PERFOR YES 2 Decify) BE HOW II	NJURY OC	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES: 2 AND
ED BY PHYSICIAN: MEDICAL		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions of the condition of the condition of the condition of the condition of the condition of the condition of the cause of the cause of the condition of the condition of the cause of t	NTRIB L H46	DUE TO DUE TO CALL	USE OF	DEATH YE	in the under the	UNC One) Home 5 PR WORK? YES 2	CERTAIN	6 Other (S) 28d. DESCRI	PERFOR YES 2 Decify) BE HOW II	NJURY OC	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES: 2 AND
ED BY PHYSICIAN: MEDICAL		If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions of the condition of the condition of the condition of the condition of the condition of the cause of	NTRIB L H4	DUE TO DUTTION TO CALCULATE TO	USE OF 21 ER/Outpet INJURY 19, 'Year') F INJURY 19tc, (Specif)	DEATH YE	in the under the	UNC One) UNC One) Home 5 PR WORK? YES 2 Office	CERTAIN peldence	6 Other (Se 28d. DESCRI	PERFOR YES 2 Decify) BE HOW II	NJURY OC	COURED or Or Aural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES: 2 AND
ED BY PHYSICIAN: MEDICAL		If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions of the condition of the condi	NTRIB	DUE TO DUTTION TO THE TO CALCONNECTION OF THE TO CALCONNECTION OF THE TOTAL CONTROL OF THE TO	USE OF 20 ER/Outpet INJURY sy, Year) Trinjury Tr	DEATH YE	In the under S NC NCH (Check onth OTHER: 4 Nursing E OF URY M street, factory	UNC One) Home 5 Re C. INJURY AT WORK? YES 2 office	CERTAIN ealdence NO No	6 Other (S) 28d. DESCRI 26f. LOCATIC City or R	PERFOR YES 2 Decity) BE HOW II ON (Street ewn., State)	NJURY OC	CORED or Aural F	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES: 2 AND
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COMPLETED BY PHYSICIAN: MEDICAL		If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions of the condition of the condi	NTRIB	DUE TO DUE TO DUE TO CALL DESCRIPTION OF CALL	USE OF 20 ER/Outpet INJURY sy, Year) Trinjury Tr	DEATH YE	In the under S NC NCH (Check onth OTHER: 4 Nursing E OF URY M street, factory	UNCONE) Home 5 PA C. INJURY AT WORK? YES 2 office deta and place	CERTAIN ealdence NO No	6 Other (Sc 2ed. DESCRI 2ef. LOCATIC City or R to the cause(s)	PERFOR YES 2 Decity) BE HOW II ON (Street ewn., State)	NJURY OC	CURED or or Rural F	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES: 2 AND
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

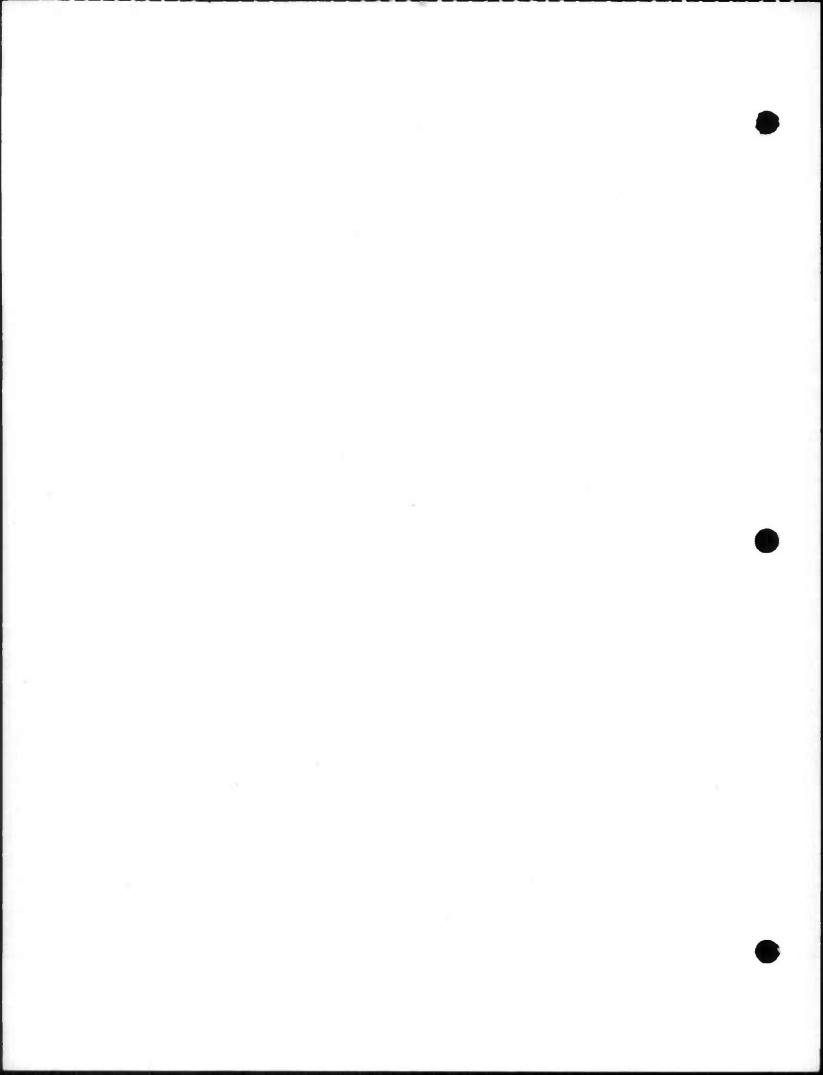
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL, DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
N	1. DECEDENT'S NAME (First, Middle, Last	at)				2. DATE OF DEATH		3. TIME OF DEATH			
3	ì	Eleanor	Catherine	MacRa	2	February	26. 19	95 4:00 P M			
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6.	BIRTHPLACE (State or Foreign			
	015-09-6373	1 🗌 M 2 🗓 F	83 yrs.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Feb. 16,		Country) lassachusettes			
	9e. FACILITY NAME (If not institution, give	e street and number)		96. CITY, TOWN	OR LOCATION OF DE						
E C	Althea Woodland	Nursing Home	2	Silve	r Spring						
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN										
DIRECTOR		ntgomery		v, town on Local lver Spi				10d. INSIDE CITY LIMITS?			
	Maryland Mon	negomery	51					1 X YES 2 NO			
¥	701 McNeill Road			10	20910		10g. CITIZEN	OF WHAT COUNTRY? USA			
FUNERAL	11. MARITAL STATUS										
요	1 Never Married 2 🖔 Merried	12. WAS DECEDENT EVI	rES 2 X NO	13. WAS DE If yes, s	CENDENT OF HISPAN pecify Cuben, Mexican	IIC ORIGIN? (Specify Yes	or No — 14.	RACE American Indian, Black, White, etc.			
'n	3 Widowed 4 Divorced	IF YES, GIVE WAR O	PR DATES	1 🗆 YE	S 2 X NO Specify	r		Specify: White			
	15. DECEDENT'S ED		16e. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BUS	SINESS/IND/193	· DV			
-	(Specify only highest gra-	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during m	ost of working	Too. Kind of Bo.	JINESS/INDOS/	n1			
7	Listing (0-12)	2	Homem	aker		Own Hon	ne				
COMPLEIED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle, Malden	Surname)				
	Dennis Sullivan				Delia	Kidney	,				
S B	De. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Nur					Route Number, City or Tow	n, State, Zip Coo	de)			
-	William B. MacRa	e	701 M	cNeill 1	Road Silv	er Spring,	Mary1	and 20910			
	20e, METHOD OF DISPOSITION 1 N Buriel 2 Cremetion 3 Re		20b. PLACE AND DATE		lame of	DATE 20c. LO	CATION — City	or Town, State			
	4 Donation 5 Other (Specify)	moval from State	George Was	ther place) Shington	Cemeter	y 3/2/95 A	delphi	Maryland			
	21. SIGNATURE OF FUNERAL SERVICE L			22. NAME A	ND ADDRESS OF FAC	CILITY					
	* limathy	es Ca				llins Fune		me, Inc. or. MD 20901			
Ħ	23. PART I. Entar the diseases, or	r complications that cau	used the death. Do i								
- 1	enock, or heart failure	e. List only one ceuse o	n eech iine.		out of dying, such	r as cardiec or respi	retory errest.	Intarval Between			
ł	iMMEDIATE CAUSE (Finel disease or condition							Onsat end Death			
ł	resulting in death)	s. Alzheimer:	S GISEASE	E).				2 Years			
,								6 Months			
	Sequentially list conditions, THE TO (OR AS A CONSEQUENCE OF)										
5			AS A CONSEQUENCE O	cause. Enter UNDERLYING							
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OR A	DIREC	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	tem
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95 07924 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH MARS MILLER 6. FEBRUARS 28 1995 9:2 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 - M 2 X F HOURS 217 - 07 - 8740VBS Jan 06, 1903 Maryland Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Howard County General Hospital Columbia Howard RESIDENCE OF DECEDENT 10e. STATE 10b COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard Laurel 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9526 N. Laurel Road 20723 USA 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ₺ NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE --- American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 YES 2 NO Specify. 3 🔣 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) Grade 6 Telephone Operator Telephone Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Columbus Campbell BE Mary Ann Yingling 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Louise Duck 9526 N. Laurel Road, Laurel, Maryland 20723 20a. METHOD OF DISPOSITION
1 X Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State ☐ Donellon 5 ☐ Other (Specify) Meadowridge Memorial Park 3/3 Dorsey, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onaet and Death disease or condition DUE TO (OR AS A CONSEQUENCE OF): 24 hrs reaulting in death) DETASTATIE ANEXOCARCINOMA OF CECUM TO CICED CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING EUOCARSINOMA CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO 118-116 PHYSICIAN: BY

NO DC					1 U YES 2 NO	COMPLETION OF CAU OF GEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				28. PLACE OF DEATH (C	heck only one)	
1 TES 2 NO	HOSPITAL: 1 Pinpatient 2 ER/Outpatient	3 DOA	6 ☐ Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigatio	28e. OATE OF INJURY (Month, Dey, Year)	28b. TIM		28c. INJURY AT WORK? 1 YES 2 NO	28d. OEŞCRIBE HOW INJURY OCCU	RED
3 Suicide a Could not be determined	28e. PLACE OF INJURY — At building, etc. (Specify)	28e. PLACE OF INJURY — At home, ferm, street, fectory, office				Rural Route Number,

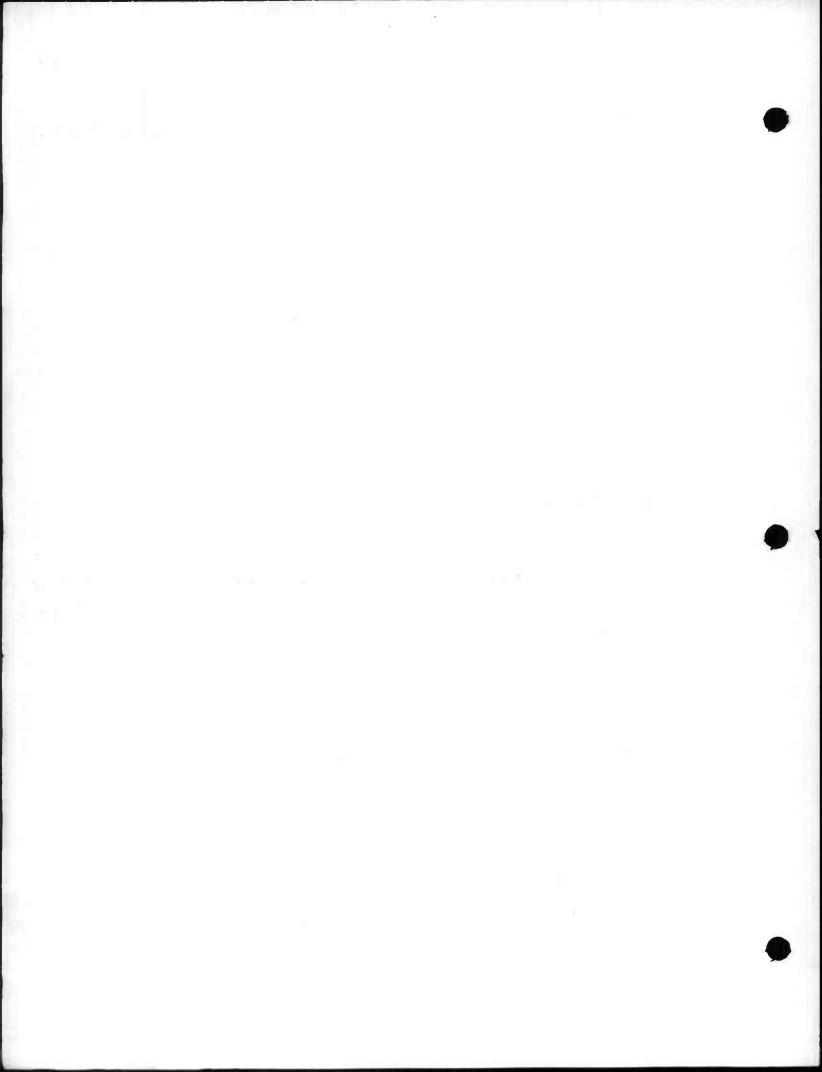
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) and menner on stated. 2 _ MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and menner as stated.

296. SIGNATURE AND TITLE OF CONTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

Mislace & Macoz M.S.	030763	1 March 1, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) MICHAELO MALON, M.D. 11085 (171)		

MAR 0 7 1995 32 REGISTRAR'S SIGNATURE alia Davelson Rondall

DHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

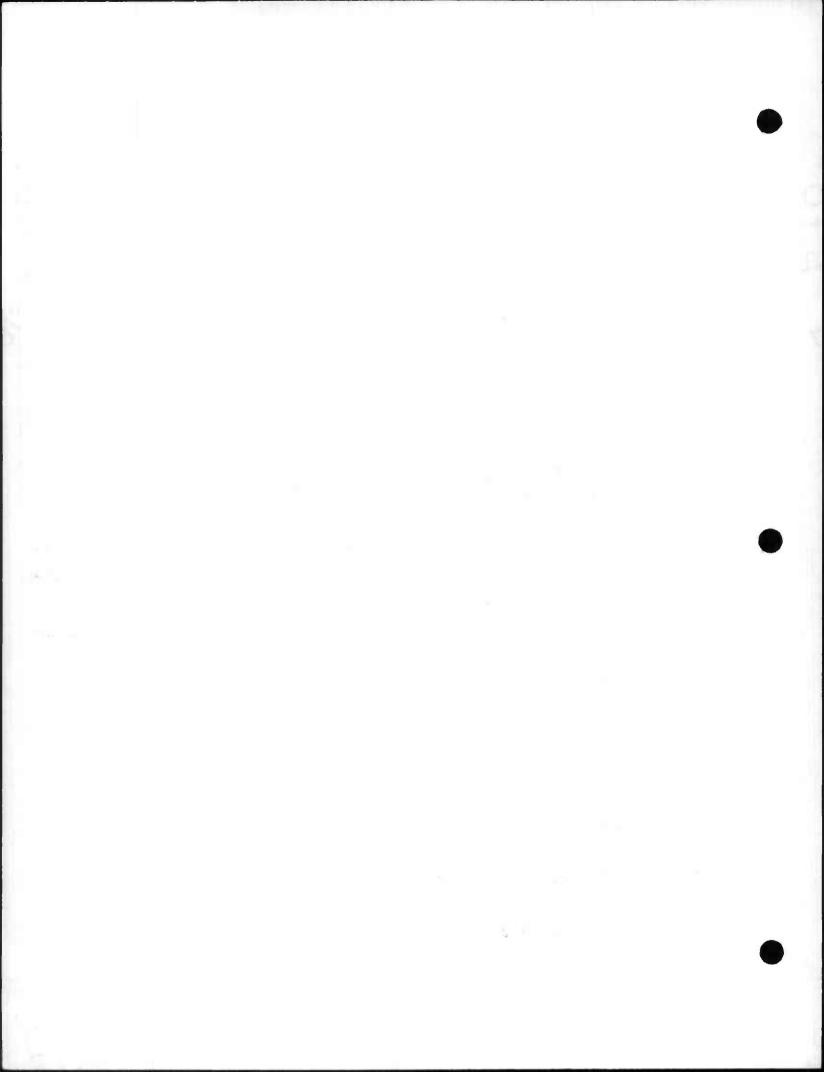
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	-mire	CALE	F DEATH		REG. NO),			
	1. DECEDENT'S NAME (First, Middle, Last)							ATE OF DEATH			3. TIME OF DE	ATH
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	14110111111		6. AGE (In yrs. last		F UNDER 1 YEA	R IF UNDER 24 HRS.	_	EB 28	199		1.6:00 A	
				"	MONTHS DAY			Month, Day, Year)		S. BIRT	HPLACE (State or try)	Foreign
		1 M 2 F	_68	YRS.	10.00	194	JA	N 27 19	927	CAN	IADA	
-	9e. FACILITY NAME (If not institution, give stre	eet and number)			9b. CITY, TOW	N OR LOCATION OF	DEATH		9c. COU	NTY OF D		
DIRECTOR	MEMORIAL HOSPITA	AL			CIMI	BERLAND			A	TTTO	3 4 3 777 7	
Ĕ	RESIDENCE OF DECEDENT				COM	DEKLAND			I A	LLEC	ANY	
Ä	10a. STATE 10b. COUNTY			10c, CITY	TOWN OR LO	CATION					10d. INSIDE CIT	ΓY
ă	MARYLAND ALLE	EGANY		LAVALE							LIMITS?	7
	10e. STREET AND NUMBER	7011111		101, ZIP CODE					1 10 0 000			
RA				107. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	675 NATIONAL HIGH					21502			U.	S.A.		
5		12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARA	MED	13. WAS D	ECENDENT OF HISP	ANIC OF	RIGIN? (Specify Yes	s or No-	14. RACI	E — American Inc	ilen,
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	3 Wildowed 4 Divorced					A.	,			Opec	"WHITE	
COMPLETED	15. DECEDENT'S EDUCA	ATION	16a. DEC	CEDENT'S L	SUAL OCCUPA	ITION		16b. KIND OF BU	SINESS/IND	USTRY		
Ш	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Giv	ve kind of w Do NOT use	ork done during retired.)	most of working						
7	12 + 3	College (1-4 of 5+)		IIOI	IOD TERM	ID TO						
Σ	17. FATHER'S NAME (First, Middle, Last)			HUL	JSE KEF	7		HOUSE		PER		
						18. MOTHER'S N	IAME (F	irst, Middle, Meiden	Sumeme)			
8	DR. STANLEY SUFF	EL				ADEL	AIN	DART				
2	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS (Street	et and Number or Rura	I Route	Number, City or Tow	n, State, Zip	Code)		
F	DR. LOUIS MOULD		671	5 NAT	TONAT	HIGHWAY	T A 17	ATE MADS	T ABID	0	1500	
	20e. METHOD OF DISPOSITION		20h PLACEAL	NDDATEO	FDISPOSITION	(Nama of		DATE 20c. LO	CATION -	Other as To	1502	
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1.70	4 Donation 6 Other (Specify) Removal from State CUMBERPANDER CREMATORY FEB 28 1995 CUMBER							TIDEK	LAMD	FIARILA	MD	
	21. SIGNATURE OF FUNERAL SERVICE CO.	21. SIGNATURE OF FUNERAL SERVICE ALCENSES					MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND					
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	snock, or neert isliure. List only one ceuse on each line.											
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MANNER OF DEATH 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	DUE TO (O DUE TO (O DUE TO (O CONTRIBUTING TO CAU BUTE TO CAU HOSPITAL: Inpatient 2 = E 28e. OATE OF IN (Month, Day. 28e. PLACE OF Is building, etc.	RAS A CONSECUTION AS A	UENCE OF) UENCE OF)	the underly the underly NO (Check only or OF RY M 1 Treet, factory, of	ing cause given in WCIOPL UNCERTA TO OTHE S RESIdence NJURY AT WORK? YES 2 NO Note and place, and du , death occured at the 29c. LICENSE NU	n Part I	24a. WAS AN PERFOR 1 VES 2 Other (Specify) DESCRIBE HOW II LOCATION (Street a City or Yown, State) couse(e) end mandate end place, an	AUTOPSY IMED? NJURY OCC and Number	or Rural F	WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 O	FINDINGS 1 TO CAUSE NO
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (O DUE TO (O	eath but not re SE OF DEAT 26. PLACE ER/Outpatient 3 [INJURY — At home C. (Specify) OF DEATH (ITEM)	UENCE OF) UENCE OF)	the underly NO (Check only or OTHER: 4 Nursing H OF W I cat the time, da I at the time, da I in my opinion	ing cause given in YGOOPL UNCERTA TO OTHER S Residence NURY AT WORK? YES 2 NO flice The end place, end du , death occured at the 29c. LICENSE NI 29c. LICENSE NI	IN 28d.	24a. WAS AN PERFOR 1 YES 2 Other (Specify) DESCRIBE HOW II LOCATION (Street a City or Yown, State) ceuse(a) and mandate and place, an	AUTOPSY IMED? NJURY OCC and Number	or Rural F	WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 O	FINDINGS 1 TO CAUSE NO
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (O DUE TO (O DUE TO (O CONTRIBUTING TO CAU BUTE TO CAU HOSPITAL: Inpatient 2 = E 28e. OATE OF IN (Month, Day. 28e. PLACE OF Is building, etc.	eath but not re SE OF DEAT 26. PLACE ER/Outpatient 3 [INJURY — At home C. (Specify) OF DEATH (ITEM)	UENCE OF) UENCE OF)	the underly NO (Check only or OTHER: 4 Nursing H OF W I cat the time, da I at the time, da I in my opinion	ing cause given in YGOOPL UNCERTA TO OTHER S Residence NURY AT WORK? YES 2 NO flice The end place, end du , death occured at the 29c. LICENSE NI 29c. LICENSE NI	IN 28d.	24a. WAS AN PERFOR 1 VES 2 Other (Specify) DESCRIBE HOW II LOCATION (Street a City or Yown, State) couse(e) end mandate end place, an	AUTOPSY IMED? NJURY OCC and Number	or Rural F	WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 O	FINDINGS 1 TO CAUSE NO

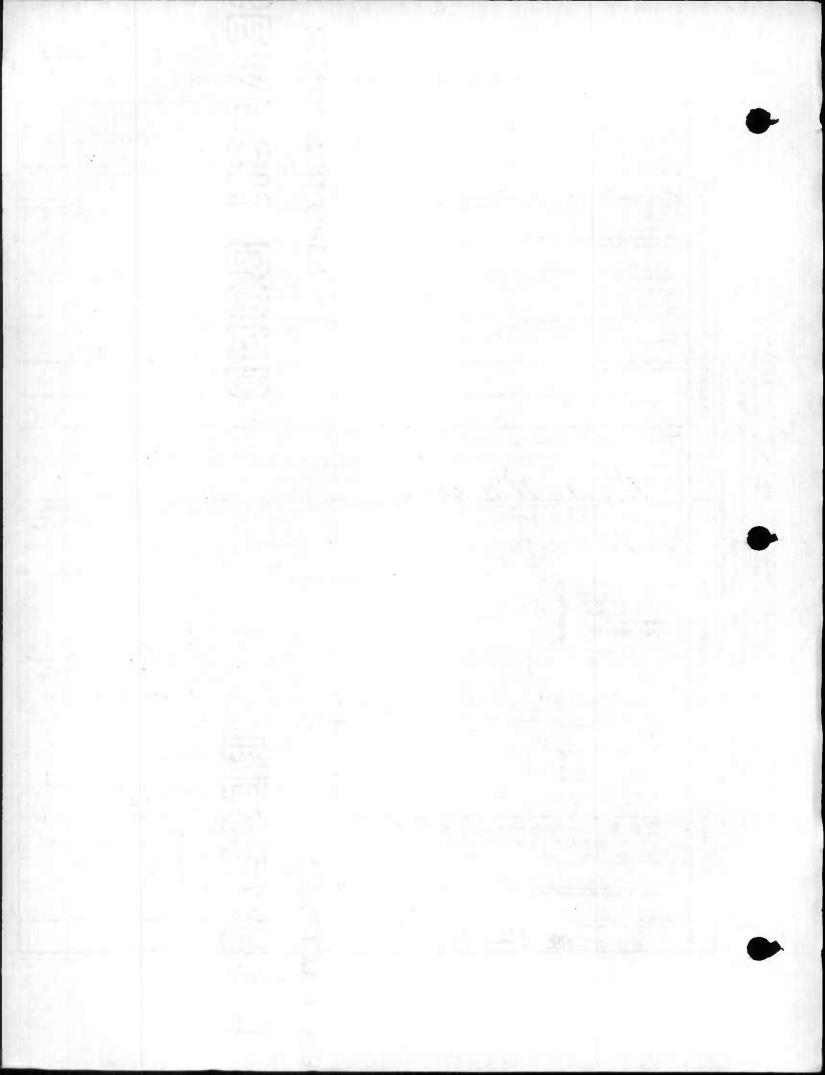


BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should if the within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be fled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notiffed at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR							
1. OECEOENT'S NAME (First, Middle, La	st)	OLITITIE .	ATE OF D	-AIII	REG. NO. 2. DATE OF DEATH MONTH DAY	YEAR	3. TIME OF OEATH
LEONARD GARLA				. 39	FEB 26, 19		4:46 P M
4. SOCIAL SECURITY NUMBER 217 10 4812 9e. FACILITY NAME (# not institution, gh	1 → M 2 □ F 7	9 YRS.			7. DATE OF BIRTH (Month, Day, Year) MARCH 27,1	915 MARY	LAND
CUMBERLAND VILLA			CUMBERI		AIH	ALLEGA	
MARYLAND A	NTY ALLEGANY		OSTBURG				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
10a. STREET AND NUMBER			10f. ZIP	CODE		10g. CITIZEN OF	WHAT COUNTRY?
18 POWELL'S LAN				21532	2342	U.S.A.	
1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 T NO	If yes, specify	Cuben, Mexica NO Specify	ilC ORIGIN? (Specify Yee on, Puerto Rican, atc.)	Special	E — American Indian, sk, White, etc. oily: WHITE
15. OECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)		16a. DECEOENT'S US (Give kind of work life. Do NOT use n	k done during most of	working	16b. KIND OF BUSI	NESS/INDUSTRY	
8 17. FATHER'S NAME (First, Middle, Last)		SHIPPING			KELLY S ME (First, Middle, Meiden S		ELD TIRE CO.
ISSAC MORO	GAN				RGARET_ALL		
19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Town.		
CAROL M THRNER	20	213 ALI			OATE 20c. LOC	21532 ATION — City or T	Court State
20a METHOD OF DISPOSITION 1 ABuriel 2 Cremation 3 R 4 Donation 5 Other (Specify)		metery, crematory or other	r place)		1, 1995 FRO		
21. SIGNATURE OF FUNERAL SERVICE	LIGENSEE	O.S.T. BILLIKE ST.	22. NAME AND A	DDRESS OF FA	CILITY		PH 21332
> ///arila	7/1/10	Dellers 1			HOME, P.A		500
23. PART i. Enter the diseases,	or complications that cause	d the death. Do not	enter the mode	of dying, suc	FROSTRIIR	story arrest,	Approximate
IMMEDIATE CAUSE (Final	re. List only ona ceuse on		, '. 1	0 0	1		Interval Between Onset and Death
disease or condition resulting in death)	. trobable 1	zate Myo A CONSEQUENÇE OF):	andial,	Infan	dion		30mintes
		A CONSEQUENCE OF):		,			1/m/en mb
Sequentially list conditions,	O.	CONSEQUENCE OF	1 oures	ere			arii(rus)
if any, leading to immediate cause. Enter UNDERLYING	6	V					
CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):					
reaulting in death) LAST	d						
PART II. Other aignificant condit	tions contributing to death	but not resulting in	the underlying ca	use given in			b. WERE AUTOPSY FINDINGS
Diahetes 1	helletes				PERFORI		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
_ sich sin	us Syndron	e			-		1 PES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OF OEATH (Ch	eck only one)		
1 TYES 2 TONO	1 Inpetient 2 ER/Out		OTHER: Rivering Home 5	Residence	8 Other (Specify)		
27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b, TIME (Y WORK?	AT 2 NO	28d. DEŞCRIBE HOW IN	JURY OCCURED	
3 Suicide 8 Could not 4 Homicide determined	building, atc. (Sp.	Y — At home, ferm, atre	eet, fectory, office		28f. LOCATION (Street at City or Town, State)	nd Number or Rural	Route Number,
	IYSICIAN: To the best of my know						(e) end menner ee stated.
29b. SIGNATURE AND TITLE OF CERT	Pier		29	0. LICENSE NUI			D (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, Pr	rint)	0-1-1	153		, ,,
SUNIL K. GUPTA,	M.D., 625 KE	NT AVE., (CUMBERLAN	D, MD	21502		A STATE OF
31. DATE FILED (Month, Day, Year) MAR 0 1 195	5 REGISTRAR'S SIG	nature dall			201		
177							DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the first hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.

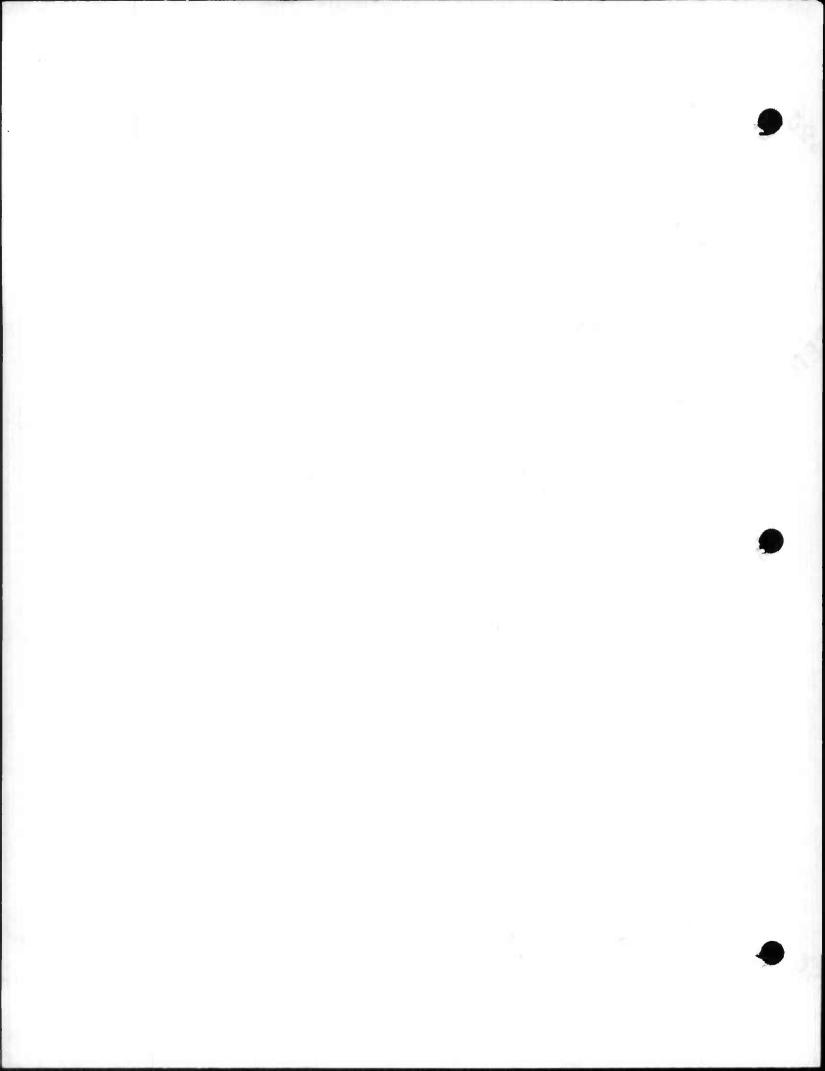
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	HEGISTHAN				ICATE			-	- 11	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, La	est)							2. DATE OF I	DEATH		YEAR	3. TIME OF DEATH
	JAMES	EDWARD		MAR	TIN			- }	Februa		24, 1995 10:55 AM		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. las	st birthday)	IF UNDER 1	YEAR I	F UNDER 24	_	7. DATE OF B	HRTH	T , 1		IPLACE (State or Foreign
	220-10-7392	1 🖫 M 2 🗆 F	77	YRS.	MONTHS	DAYS H	IOURS I	MIN.	(Month, De		117	Counti	(۲/
	9a. FACILITY NAME (If not institution, g	ve street and number)			9b. CITY, T	OWN OR I	LOCATION		Feb 28	3, 1		NTY OF D	MD
Œ	W 1 H 1	. 1						OF DE	AIII				
DIRECTOR	Memorial Hospi	al			Cum	berl	and				A11	egan	У
EC	10a. STATE 10b. COL	INTY		10c. CIT	Y, TOWN OR	LOCATION	N	_					10d. INSIDE CITY
E	MD A1	legany			mberland					- 1	LIMITS?		
	10e, STREET AND NUMBER										1 X YES 2 NO		
¥.	302 Massachuse	tte Arronno			101. ZIP CODE 21502					10g. CIT		WHAT COUNTRY?	
9						21	1302				0.5	F3.	
FUNERAL	11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2				13. WA	S DECEN	DENT OF	IISPANI	IC ORIGIN? (S _I	pecify Yes	or No-	14. RACE	E — American Indian, k, White, etc.
BY	3 Wildowed 4 Divorced	IF YES CIVE W	AR OR DATES		10	YES 2	NO NO	Specify:	i, ruento nican :	i, etc.)			
												7	white
臣	15. DECEDENT'S I (Specify only highest g	EDUCATION rade completed)	/G	ive kind of v	USUAL OCC	UPATION	of working		16b. KIN	D OF BUS	INESS/INC	DUSTRY	
14	Elementary/Secondary (0-12)	College (1-4 or 5 +	life.	. Do NOT us	se retired.)								
COMPLETED	12		S.	דווודר	ng De	pt.			16	exti.	Le		
8	17. FATHER'S NAME (First, Middle, Last)					10			AE (First, Middle				
BE (William T. M	artin					Ced	cel:	ia (Dr	essm	an)		
	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS (S	Street and i	Number or	Rural R	oute Number, C	ity or Town	, State, Zic	Code)	
2	Mildred V. Mar	tin	30)2 Ma	ssach	uset	ts A	ve:	Cumbe	rlar	d. M	D 2	1502
	204. METHOD OF DISPOSITION			_	OF DISPOSITI				DATE	_			
	1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	Stelery, on						02/27		CATION — City or Town, Stata Aberland, MD		
- 1	21. SIGNATURE OF FUNERAL SERVICE	LICENSEF.	1	1			-4	OF SAC					
		1	11		Sca	arpe.	IIi	un	eral H	ome			
	Garest.	& Can	RIL	1	Cu	nber.	Land	, M	D 215	02			
	23. PART I. Enter the diseases,	or complications that	csused the de	eth. Do r	not enter th	e mode	of dying	, auch	as cerdiac	or respin	ratory an	reat,	Approximata
										interval Between			
disease or condition								Ouser and pestil					
	disease or condition	HAA	NO 101	D+"	VEN	MX	1 / /	ツVハ	1 +0	イムベ	$\mathcal{N}V$	X	19-21.0
	disease or condition resulting in death)	a. HON	OR AS A COMPLET	UENCE OF	V EVY	nve	M	V	110			K	2-3 mg
_	resulting in death)	- P	(OR AS A COMBE	LIENCE OF	7 em	TUE	Ne		110			<u>L</u>	2-3 ml
NOI	resulting in death) Sequentially list conditions,	- a F	(OR AS A CONSECUTION OF AS	no	3.	nve	M	1	110				23ml
ATION	resulting in death)	- a F	nemu	no	3.	Ae	me	N	ree		2 ,		23ml 3mg
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b. OUE TO	nemu	DUENCE OF	3. Au	Ne	m	R	x se		2 ,	L	23ml 3ms
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. OUE TO	(OR AS A CONSEC	DUENCE OF	3. Au	Ae	m	R) Fe		2 ,	L .	23ml 3ms
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	b. OUE TO	(OR AS A CONSEC	DUENCE OF	3. Au	Ae	m	R) FC		2 ,	L .	23ml 3ms
AL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONSECUTION AS	DUENCE OF	2) 1: De	Ale riying ce	well	en in F	20rt 1. 24a	. WAS AN		246.	3 mg
ICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	c. DUE TO	(OR AS A CONSECUTION AS	DUENCE OF	2) 1: De	Ae viriying ce	Me euse give	en in F		PERFORI	WED?	24b.	AVAILABLE PRIOR TO
EDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	c. DUE TO	(OR AS A CONSECUTION AS	DUENCE OF	2) 1: De	Ae riying ce	Meuse give	en in F			WED?	24b.	
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Σ	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	c. DUE TO d	(OR AS A CONSECUTION OF DEA	DUENCE OF SWENCE OF	r):				_ 10	PERFORI	WED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significant conditions. DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	c. DUE TO d	(OR AS A CONSECUTION OF DEA	DUENCE OF SWENCE OF	in the unde				_ 10	PERFORI	WED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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Σ	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	d. DUE TO	(OR AS A CONSECTION OF THE CON	DUENCE OF DEAT	in the unde	one)	UNCER	TAIN	_ 10	PERFORI	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DEAT	in the unde	y one) Home 5 C. INJURY WORK?	UNCER	TAIN	1 C	PERFORI	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: M	PART II. Other significant conditions of the conditions of the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition of the condi	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DEAT DOA 28b. TIMI	in the under the	y one) Home 5 Ic. INJURY WORK? I YES	UNCER	enca 8	1 CONTROL OF CONTROL O	PERFORI	JURY OCC	CURED	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DEAT DOA 28b. TIMI	in the under the	y one) Home 5 Ic. INJURY WORK? I YES	UNCER	enca 8	1 C	PERFORI	JURY OCC	CURED	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ETED BY PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DEAT DOA 28b. TIMINJ	in the under the	y one) g Home 5 ic. INJURYY WORK? I YES , office	UNCER 5 Realds	enca 8	1 COATION City or You	PERFORI YES 2 Pecify) BE HOW IN N (Street air viv., State)	JURY OCC	CURED or Rural R	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ETED BY PHYSICIAN: M	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigated 2 Accident Investigated 3 Suicide 8 Could not detarmined 29a. CERTIFIER (Check only)	b. DUE TO c. DUE TO d. Ions contributing to NTRIBUTE TO CA HOSPITAL: 1 Dinpetient 2 28e. PLACE Of building, vsician: To the best of	(OR AS A CONSECTION OF THE CON	DUENCE OF DUENCE OF DOA 28b. TIMMINJ	in the under the	y one) y Home 5 ic. INJURY WORK? I YES office	UNCER 5 Realdor AT 7 2 N	enca 8	1 COATION City or Tow	PERFORI YES 2 POLITY POLITY N (Street air Vn, State)	JURY OCC	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ETED BY PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DUENCE OF DOA 28b. TIMMINJ	in the under the	y one) y Home 5 ic. INJURY WORK? I YES office	UNCER 5 Realdor AT 7 2 N	enca 8	1 COATION City or Tow	PERFORI YES 2 POLITY POLITY N (Street air Vn, State)	JURY OCC	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
E COMPLETED BY PHYSICIAN: M	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigated 2 Accident Investigated 3 Suicide 8 Could not detarmined 29a. CERTIFIER (Check only)	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DUENCE OF DOA 28b. TIMMINJ	in the under the	y one) g Home 5 c. INJURY WORK? I YES office	UNCER 5 Realdor AT 7 2 N	enca 8	1 C Other (Special Description of the cause(s) lime, data and	PERFORI YES 2 POLITY POLITY N (Street air Vn, State)	JURY OCC	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BE COMPLETED BY PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF CENTRAL CONTROL OF CONTROL OF CENTRAL CONTROL CONTROL OF CENTRAL CONTROL	in the under the	y one) y Home 5 c. INJURY WORK? I YES , office	UNCER 5 Realdor 7 AT 7 2 N d place, an	enca 8	1 C Other (Special Description of the cause(s) lime, data and	PERFORI YES 2 POLITY POLITY N (Street air Vn, State)	JURY OCC	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
E COMPLETED BY PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF CENTRAL CONTROL OF CONTROL OF CENTRAL CONTROL CONTROL OF CENTRAL CONTROL	in the under the	y one) y Home 5 c. INJURY WORK? I YES , office	UNCER 5 Reald (AT 7 2 N	enca 8	1 C Other (Special Description of the cause(s) lime, data and	PERFORI YES 2 POLITY POLITY N (Street air Vn, State)	JURY OCI nor as state due to the	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BE COMPLETED BY PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DUENCE OF DEAT DOA 28b. TIMMINJ ath occurre investigation of 27) (Type,	in the under the	y one) g Home 5 c. INJURY WORK? I YES, office	UNCER 5 Paaldd 7 AT 7 2 N d placa, and n occured a	o d due to the title E NUME	1 Cother (Spe 28d. DESCRIB 28f. LOCATION City or Town of the cause(s) lime, data and	PERFORI YES 2 PECIFY) PE HOW IN N (Street air viv., State) and manipleca, and	JURY OCCURNO AND AND AND AND AND AND AND AND AND AND	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BE COMPLETED BY PHYSICIAN: M	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant conditions of the condition	b. DUE TO c. DUE TO d	(OR AS A CONSECTION OF THE CON	DUENCE OF DEAT OF DOA 28b. TIMINJ me, farm, s ath occurrence of 27) (Type, cal B	in the under the	y one) g Home 5 c. INJURY WORK? I YES, office	UNCER 5 Paaldd 7 AT 7 2 N d placa, and n occured a	o d due to the title E NUME	1 Cother (Spe 28d. DESCRIB 28f. LOCATION City or Town of the cause(s) lime, data and	PERFORI YES 2 PECIFY) PE HOW IN N (Street air viv., State) and manipleca, and	JURY OCCURNO AND AND AND AND AND AND AND AND AND AND	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO



1995

Home

3. TIME OF DEATH

8P

10d. INSIDE CITY

1X YES 2 NO

White

a. BIRTHPLACE (State or Foreign

Maryland

Anne Arundel

United States

14. RACE — American Indian, Black, White, etc.

page 5 should notified

funeral director,

ysician and completely filled in by the prior to burial, cremation, or removal.

attending physician ntal Hygiene prior to

been signed by the attent. of Health and Mental

has be Dept.

After this certificate hadeath with the State D marked, or Item Hem

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After 1

use as the burial-transit permit. Pages 1, 2, 3 should

DIRECTOR

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BY

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

0

3 Suicide

4 Homicide

29b. SIGNAT

BOX 68760 P.O.

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, TO THE HOSPITAL OR ATTENDIN TO THE FUNERAL DIRECTOR: Af be filed within 72 hours after de IMPORTANT: IF Item 28 IS F

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Hattie Irene Nowell February 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR 212-74-6059 1 M 2 X F DAYS HOURS MIN. 94 YRS Nov 3 1900 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 920 Boucher Avenue Apt 3 Annapolis RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Anne Arundel Annapolis 10s. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 920 Boucher Avenue Apt 3 21403 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yea. soecify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puerto Rica 1 YES X NO Specify: Never Married 2 Merried IF YES, GIVE WAR OR DATES 3 Widowed 4 ☐ Divorced 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sn Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homemaker 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) David V. Miller Jenny T. Britten 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Nowell, 116 Chesapeake Estates Dr. Stevensville, MD 21666 29 METHOD OF DISPOSITION 1 & Buriel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Hillcrest Cemetery 4 ☐ Donation 6 ☐ Other (Specify) 2/27/95 Annapolis, MD 21. SIGNATURE OF FUNE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List **IMMEDIATE CAUSE (Finel** disease or condition_ ROD resulting in death) DUE TO OR AS A CONSEQUENCE OF: Sequentially liet conditions, if any, landing to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Sal

24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2

261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO

Approximate

Intarval Betw

Onset and Death

Ras

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

HOSPITAL: NO OTHER: 1 TYES Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) Natural 2 Accident

4 Nursing Home 5 sidence 6 Other (Specify) 28c. INJURY AT

26d, DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner as stated. ination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee stated.

TITUE OF CENTY

DIGGS NUMBER

29d. DATE SIGNED (Month, Day, Your) 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Peter Graze, M.D. 900 Bestgate Road Annapolis, MD 21401 (410-573-5300) 31. DATE FILED (Month, Day, Year)

28 1995

5 Pending

6 Could not be

determined

32. REGISTRAR'S SIGNATURE Jalia Davidsor Rendall

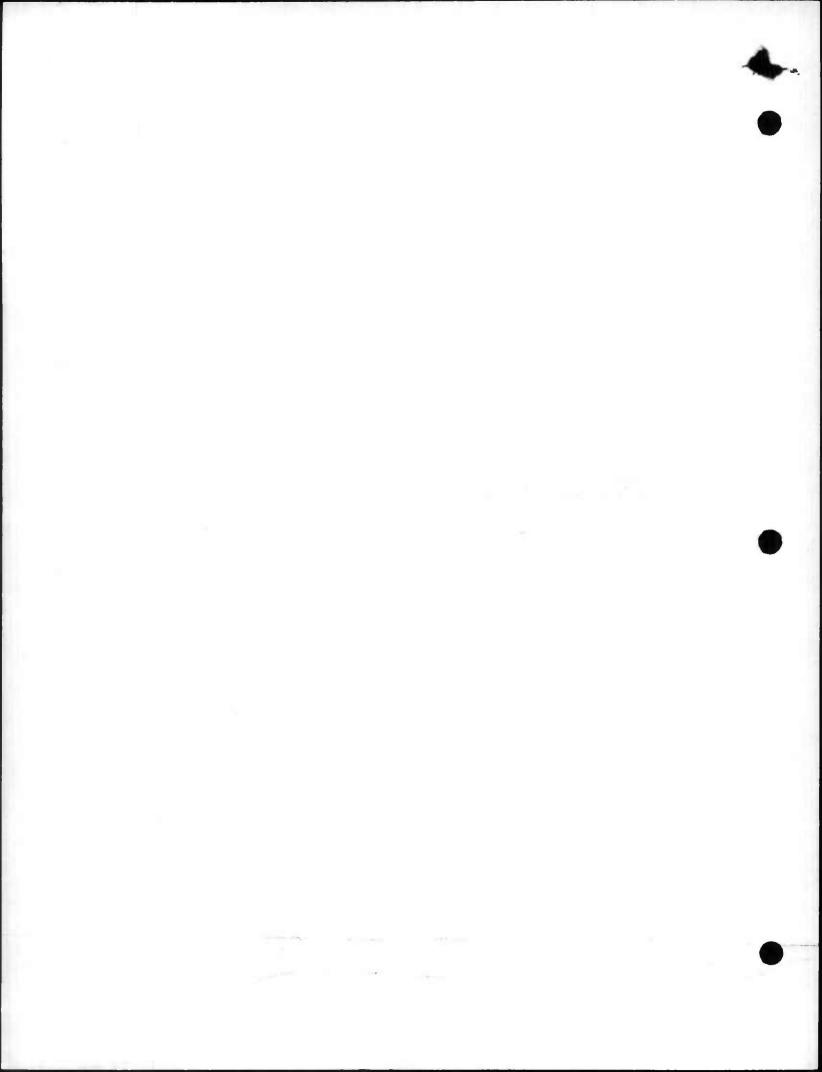
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1 - FOR STATE REGISTRAR

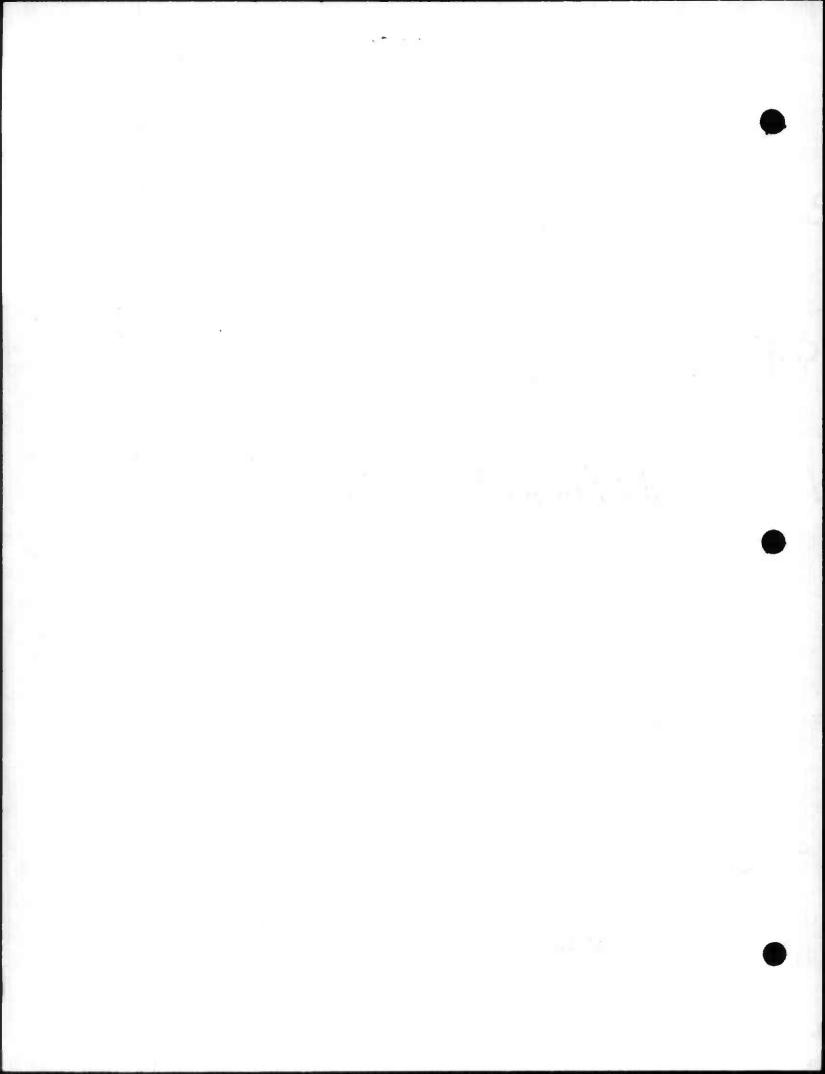
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR			CERTIF	CATE C	OF DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) Bernard	charles		Nola	12			AY	YEAR	3. TIME OF DEATH 3/22 A
	4. SOCIAL SECURITY NUMBER			s. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	Feb. 26	199		CLACE (State or Foreign
	218-07-0890	1√1√1 M 2 □ F	75	YRS.	MONTHS DA	YS HOURS MIN.	12/23/19	19	MD)
E C	9a. FACILITY NAME (If not institution, give s Carroll County		Hosi	pita1		wn or Location of D tminster	EATN		rol	
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT				r, TOWN OR LO			Car	.101.	
DIRECTOR	MD. Ca	arroll		10e. CIT		ksburg				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	2756 Old West	minster E	Pike			10f. ZIP COOE 21048	8	USA		HAT COUNTRY?
BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT E FORCES? 1	YES 2 OR DATES	□NO	If yes	DECENDENT OF NISPA I, specify Cuban, Mexico YES 2 NO Specifi		or No-	Black, Specify	
8	15. DECEDENT'S EDU	CATION	WW.T.	. DECEOENT'S	USUAL OCCUP	PATION	16b. KIND OF BU	SINESS/IND		nite
	(Specify only highest grade	Coffege (1-4 or 5+)	-	(Give kind of v ite. Do NOT us Firema	rork done during e retired.)	g most of working	Fire			
E COMPL	17. FATHER'S NAME (First, Middle, Last) Bernard France	is Nolan		177			AME (First, Middle, Malden elle Eliz		h Lo	ckard
TO B	19a. INFORMANT'S NAME (Type/Print) Thea G. Nolar	1		19b. MAILING 2756	ACORESS (Str	Westmins	Route Number, City or Tow ster Pike	n, State, Zip	code) nksb	21048 ourg, Md
	20a. METHOD OF DISPOSITION 1 String Burlal 2 Cremation 3 Rem	oval from Stata	20b. PLA	CE AND OATE O	F OISPOSITION	N (Neme of	DATE 20c. LO	CATION —	Cify or Tow	n, Slata
	4 Donalion 5 Other (Specify)		Eve	rgree	n Mer		3/1/95	Fin	ksbu	ra, Md.
	21. SIGNAL DIE OF FUNERAL SERVICE LIC	P P		1	My		eral Home			
	23. PART I. Entar tha diseases, or o	complications that co	aused tha	daath. Do n	ot antar the	MILLIS mode of dving, auc	St. WEst	mins	ter,	Md · 21
	23. PART I. Entar the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or reapiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):								Interval Betwee	
ATION		HIPOX	cia					_		14 hour
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	ASPINE PSPINE	a + 10	SEQUENCE OF	Pne	umonit	ら			4 hour
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR	R AS A CON	ISEOUENCE OF):					
	PART II. Other algnificant condition	s contributing to da	ath but no	ot reaulting i	n tha undari	ying cause given in	Part I. 24a. WAS AN	AUTOPSY	24b. \	WERE AUTOPSY FINDING
S				·			PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
A: ME	DID TOBACCO USE CONTI	RIBUTE TO CAUS	SE OF D	EATH YF	S \square NO	☐ UNCERTAI	N I			YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	26. P	LACE OF DEAT			- total			
	1 YES 2 D'NO 27. MANNER OF DEATH	1 Inpatient 2 EF		3 DOA	4 - Nursing I	Nome 5 Residence		M 44 (MA)	W. Control	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	INJ	M 1	WORK?	28d. DESCRIBE NOW I	NJURY OCC	URED	
	3 Suicide 8 Could not be detarmined	28a. PLACE OF IN building, atc.	NJURY — At . (Specify)	t home, farm, s	treel, factory, o	offica	28f. LOCATION (Street a City or Town, State)	and Number	or Rural Ro	ute Number,
O BE COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE						lo lhe cause(a) and mar lime, data and place, an			and manner as stated.
Ü	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI	MBER			Mojeth, Day, Year)
TO B	Vobert Vecke					D392	96	▶ Z	1/26/	195
	R. Ricketts M	O COMPLETED CAUSE C	C 6		Print) WE	estmin.	5 kg m	D	21	157
	MAR 0 1 1995	32. REGISTRAR'S	SIGNATOR	blall						



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	1 - FOR STATE OF MARY		RTMENT OF H		MENTAL HYGIEN		0,7,500		
	1. DECEDENT'S NAME (First, MIDDIN, Last) MATGATET MAY NO.	LMQ D	Λ	DEATH	2. DATE OF DEATH MONTH D.	AY YI	ar 3. TIME OF DEATH		
	217-78-8077 1 M X F	E (In yrs. last birthday, B1 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTY (Month, Day, Year) SEPT . 28	- 1	BIRTHPLACE (State or Foreign Country) MARYLAND		
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) CHURCH HOME HOSPITAL RESIDENCE OF DECEDENT		96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY BAL	OF DEATH TIMORE		
5	10a. STATE 10b, COUNTY	10c. CI	TY, TOWN OR LOCAT	TION		10d. INSIDE CITY			
	MARYLAND BALTIMORE		BALTIM	ORE		LIMITS?			
RAL	100. STREET AND NUMBER 722 23RD STREET	101	21218			OF WHAT COUNTRY?			
FUNER	11. MARITAL STATUS 12. WAS DECEDENT EVER	LIN U.S. ARMED	12 WAS DEC		ANIC ORIGIN? (Specify Yes		USA		
B	Type of Married 2 Married FORCES? 1 YES, GIVE WAR OR	S 2 1 NO	II yes, sp		can, Puerto Rican, etc.)	or No.— 14.	RACE — American Indian, Black, Whita, atc. Specify: WHITE		
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S (Give kind of life. Do NOT	S USUAL OCCUPATION work done during mo	ON ost of working	16b. KIND OF BUS	SINESS/INDUST	TRY		
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 +)	NONE	,		NO	NE			
111	17. FATHER'S NAME (First, Middle, Last) JOHN T. NAUMANN				SKELTON	Surname)			
TO BE	19a. INFORMANT'S NAME (Type/Print) VIRGINIA N. CRIST	196. MAILIN 501	G ADDRESS (Street a	nnd Number or Rura	NE, EASTO	n, State, Zip Coo	21601		
2	20a. METHOD O5-DISPOSITION 2 1 Burlai 2 Cremation 3 Removal from State 0		OF DISPOSITION (Na				or Town, State		
TS TE		SALISBU	other place) RY CREM	ATORY			SBURY, MD		
examiner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AN	ND ADDRESS OF F	ACILITY				
	M. E. Neverram	CES!			ERAL HOME				
nt, the medical	23. PAHT Enter the diseases, or complications that caus shock, or heert feiture. List only one cause on IMMEDIATE CAUSE (Final disease or condition resulting in death)	each line.	not enter the mo	sepsis	ch se cerdiac or reapi	ratory arrest	Approximata interval Between Onset and Death		
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):								
	cause, Enter UNDERLYING CAUSE (Disesse or Injury that initiated events C. DUE TO (OR AS	A CONSEQUENCE O	100215				2004		
HT	resulting in deeth) LAST	. 6	1. He	edena			2 days		
3 .	PART II. Other significent conditions contributing to death	but not reaulting	in the underlying	g cause given in	Part i, 24e, WAS AN	ALITOPSY .	24b. WERE AUTOPSY FINDING		
MEDICAL					PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MET.							OF DEATH?		
	DID TOBACCO USE CONTRIBUTE TO CAUSE			UNCERTA	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		OTHER:						
HYS	1 ☐ YES 2 ☐ NO				8 Other (Specify)				
	1 Natural 5 Pending (Month, Day, Year)		JURY WO	RK?	28d. DESCRIBE HOW IN	IJUHY OCCURE	20		
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28a. PLACE OF INJUR building, etc. (Sp	IY — At home, farm, ecify)	street, lactory, office		281. LOCATION (Street a City or Town, State)	nd Number or R	Turel Route Number,		
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of my knot one) 2 MEDICAL EXAMINER: On the basis of examinations of the basis of examinations of the basis of examinations of the basis of examinations of the basis of examinations of the basis of examinations of the basis of examinations of the basis						ruse(s) and manner as stated.		
BEC	296. SIGNATURE AND TITLE OF CERTIFIER	1.	ann	29c. LICENSE NU	MBER	29d. DATE SIG	GNED (Month, Day, Year)		
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D	EATH (ITEM NO. CT.	- Delet	DA	162+5	2	-19-9T		
	Richard C. Huis 600	W. W	offe s	A B	altimore	mo	21205		
	31. DATE FILED (Month, Dex. Year) 2-19-9K 32. REGISTRAR'S SIG	- hardall	V						

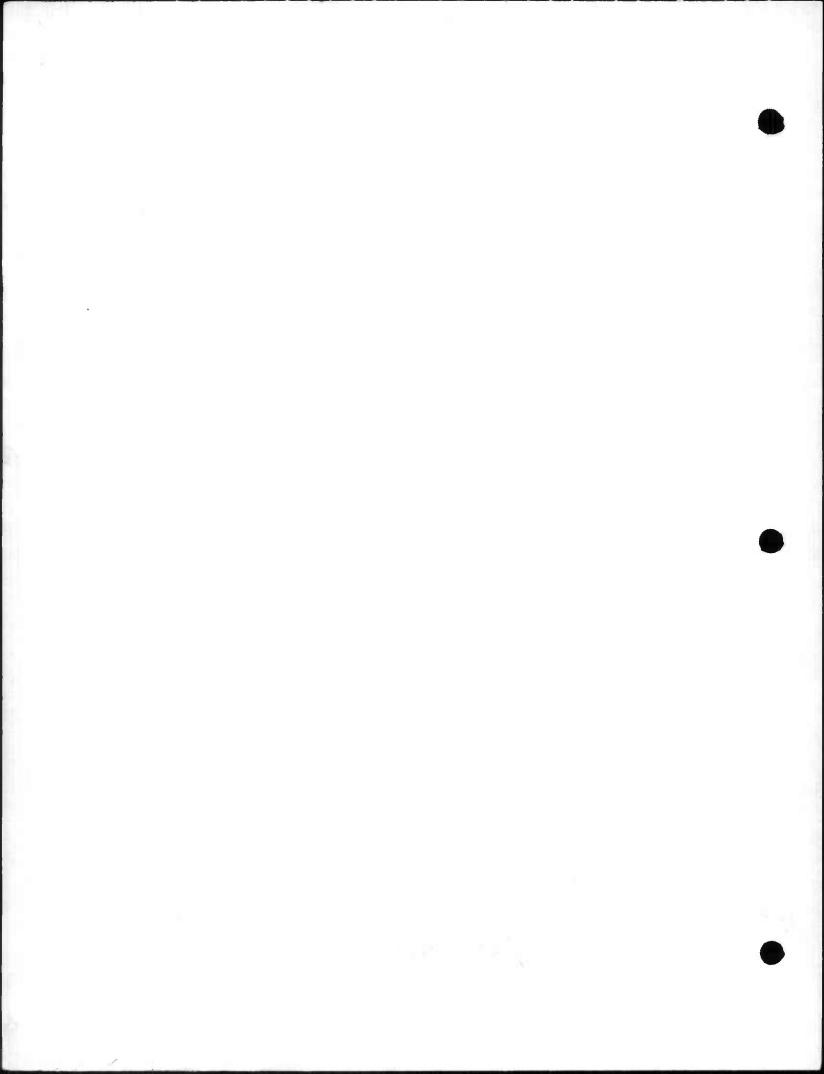


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TAL	RAL	2	=
TO THE HDSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sh	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be not
포	HE	₩ pa	ORT
I O	T Q	e fil	MP
_	_	23	-

A	FOR FOR 1 - STATE REGISTRAR	12 # 14 STATE OF	# //Ga MARYLAND / CE	DEPART ERTIFIC	MENT OF H	IEALTH AND DEATH	MENTAL	HYGIEN REG. NO.	t 9	Shel	793ty	
DIRECTOR	1. DECEDENT'S NAME (First, Middle	Philip					of DEATH DAY 15, 1995			3. TIME OF DEATN 5:00 P M		
	4. SOCIAL SECURITY NUMBER 573-40-3538	5. SEX	6. AGE (In yrs. last birthda 73 yrs		IF UNDER t YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year April 15		8. BIRTH Count		ACE (State or Foreign	
	90. FACILITY NAME (If not institution Holy Cross Hos	pital				Spring					TN	
	Maryland 106.	Montgomery	ion of a found on coontrol								d, INSIDE CITY LIMITS? Y YES 2 NO	
FUNERAL	10e. STREET AND NUMBER 2225 Forest G1		ENT EVER IN U.S. AR	1450		20910				USA	T COUNTRY?	
PLETED BY	1 Never Married 2 M Merrie 3 Widowed 4 Divorced	FORCES? IF YES, GIVE Unknow	1 X YES 2 □N WAR OR DATES VTD 1945	-1948	If yes, sp	ENDENT OF NISPA ecity Cuben, Mexic 2 NO Speci	en, Puerto Ric	en, stc.)		Black, W Specify:	American Indian, this, etc. White	
	(Specify only higher Elementary/Secondary (0-12)	College (1-4 or 5-1-	5+) C 1/1/0.	ve kind of wo	sual occupations do not do not do not during mo retired.) brariar	st of working		ibrar		Cong:	ress	
	17. FATNER'S NAME (First, Middle, Leat) Reita Nagao 18. MOTHER'S NAME (First, Middle, Meiden Surrame) Tsuyano Eguchi											
TO TO	196. INFORMANT'S NAME (Types/Print) Julia A. Nagao 190. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 201. METHOD OF DISPOSITION 201. METHOD OF DISPOSITION 202. METHOD OF DISPOSITION 203. METHOD OF DISPOSITION 204. METHOD OF DISPOSITION 205. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 204. METHOD OF DISPOSITION 205. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)											
or must	20b. PLACE AND DATE OF DISPOSITION 1											
al examin	> Steven!	ls J. Co niversit	Collins Funeral Home, Inc. ity Blvd.W. Sil.Spr. MD 20901									
other traumatic event, the medical examiner must be notified at once. TIFICATION TO BE COM	23. PART I. Enter the disesses, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory errest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disesse or condition resulting in death) a. Cardio Pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF):									est,	Approximats interval Between Onset and Death 5 minutes	
FICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING									6 months		
5 1	CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):											
: MEDICAL CI	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 ☒ NO									AM CO	Ib. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
is marked, or item 23 sho D BY PHYSICIAN: M		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
	1 YES 2 NO 27. MANNER OF DEATH 1 N Neturel 5 Pendin	1 ☐ YES 2 ☐ NO						B Other (Specify) 28d. DESCRIBE NOW INJURY OCCURED				
	2 Accident Investig 3 Suicide 8 Could 4 Homicide determi	pation 28e, PLACE building	OF INJURY — At hor g, stc. (Specify)	M 1 VES 2 NO URY — At home, ferm, street, factory, office Specify)			281. LOCATION (Street end Number or Rurel Route Number, City or Town, State)				a Number,	
ED C	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner se stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner se stated.											
<u>≃</u> □	(Check only 1 X CERTIFYING										d menner ee stated.	

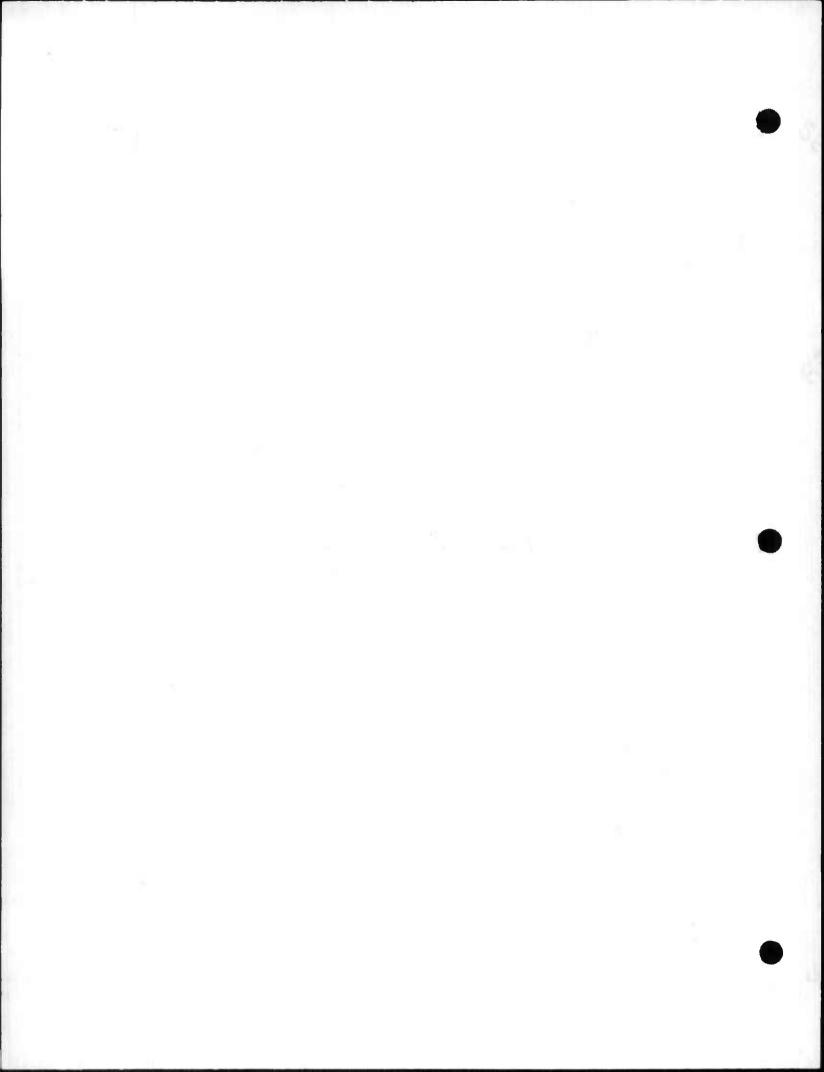
Edgar H. Levin, M.D. 9801 Georgia Ave. #341 Silver Spring, MD 20902
31. DATE FILED (Month, Dev. Year) 32. REGISTRAR'S SIGNATURE

WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)



the death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	220-2 9e. FACILITY Shady RESIDEN 10e. STATE 883 11. MARITAL 1
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incomplete of may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTIANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.) BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	23. PART II IMMEDIATI disease or resulting ii Sequential if any, lead cause. Ent CAUSE (Di that initiate resulting ir PART II. Of DID TO 25. WAS CASI EXAMINER 1 YES 27. MANNER 2 Acck 3 Suici 4 Homi 290. CERTIFIE (Check or one)

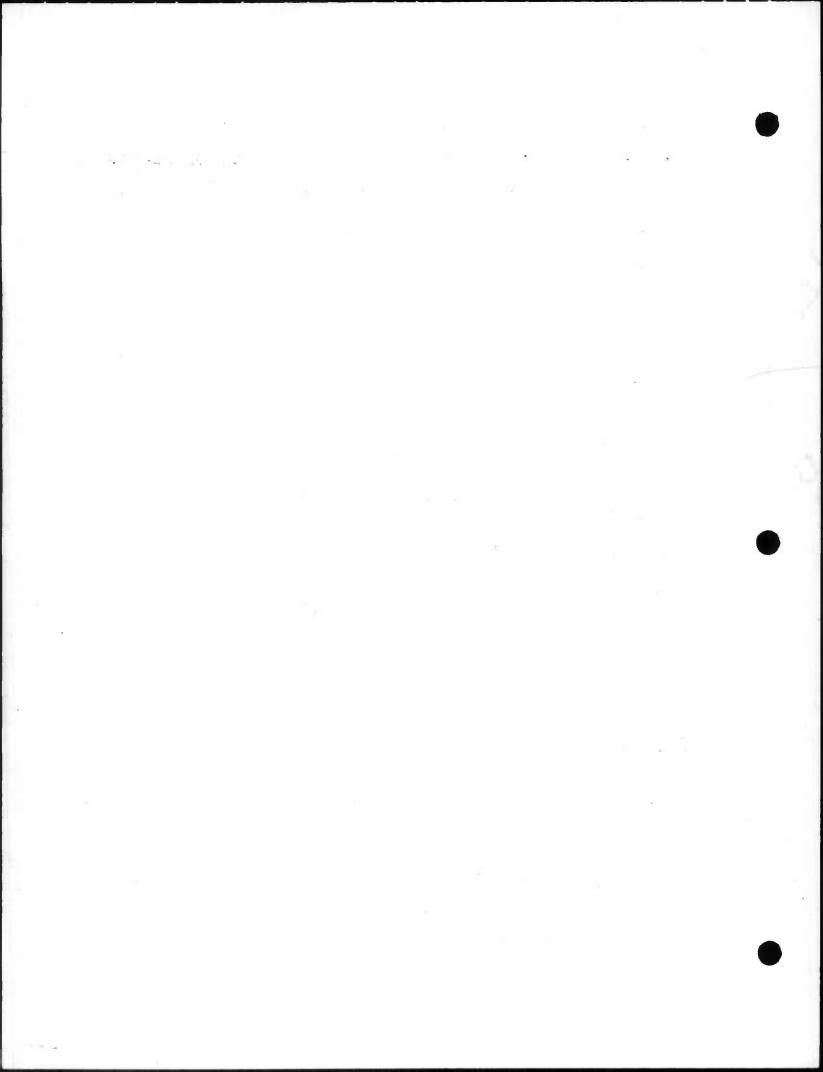
	1 1 7	<i>t</i>	2/	/			4.0	ī		95	j 0	7932
	1 - STATE REGISTRAR	2	STATE OF N	MARYLANI	D / DEPAR CERTIF	THENT OF CICATE OF	HEALTH AN	ND MENT	AL HYGIEN	E	ou,	nty
	1. DECEOENT'S NAME (First, Middle 4. SOCIAL SECURITY NUMBER	Die	ma	nn	RO	ruan 27 1945 10:57			0:57 A "			
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 X F 6. AGE (in yn 2 20-28-1857 9a. FACILITY NAME (it not inetitution, give street and number)				78. list birthday) YRS. F UNDER 1 YEAR F UNDER 24 HRS. DAYS HOURS MIN. 9b. CITY, TOWN OR LOCATION OF D			M. NOT	Nov. 15, 1932			ACE (State or Foreign
OR	Shady Grove Adventist Hospital					Rockville					ntgome	
DIRECTOR	RESIDENCE OF DECEDE 10a. STATE 10b. 0	COUNTY			10c. CIT					d. INSIDE CITY		
	Maryland M		Ga			LIMITS? 1 💢 YES 2						
FUNERAL	100. STREET AND NUMBER	land	Dwino			,	or. zip code 20877	,				AT COUNTRY?
UNE	8833 N. Westland Drive 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U				. ARMED		SPANIC ORIG	United St RIGHN? (Specify Yea or No. 14. RACE - /			American Indian	
ВҰ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d	FORCES? 1 IF YES, GIVE W		2 K NO If yes, specify Cuban, Mexican, Puerto				Specify:			White
ETED	15. DECEDENT (Specify only higher	'S EDUCAT st grade cor	TION mpleted)	16a	. DECEDENT'S	USUAL OCCUPAT work done during ri se retired.)	ION ost of working	10	Sb. KIND OF BUS	SINESS/IND	USTRY	111200
4PLE	Elementary/Secondary (0-12)	1	College (1-4 or 5+)	Mana				Retail	Store	e	
COMPL	17, FATHER'S NAME (First, Middle, L			8	18. MOTHER		, Middle, Maiden					
BE	Ellis Bayard 19a. INFORMANT'S NAME (Type/Pris		ons		19h MAII ING	ADDRESS (Street	Mabel			ennis		
2	Robert A. Niem	ann				. Westl						20877
	20a. METHOD OF DISPOSITION 1 K Burlel 2 Cremellon 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE ANDDATE OF DISPOSITION (Name of camelary, cremetary, or other place) Parklawn Memorial Park 3/3/95 Rockville, Mary											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Hom												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
				700-	ven	Gaith	ersburg	g, MD	208//			
	IMMEDIATE CAUSE (Final disease or condition	es, or con allure. Lis	pplications that only one cause	caused the	daath. Do f	not anter the m	ode of dying,	such as ca	rdiac or reapi			Approximate interval Between Onset and Death
	IMMEDIATE CAUSE (Final	es, or con allure. Lis a	Disem	inate	daath. Do filne.	not anter the m	ode of dying,	such as ca	rdiac or reapi			interval Between
TION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	as, or com allure. Lis a	Disem DUE TO Meta	or as a con	ilne.	Trees	ode of dying,	such as ca	208// rdiac or reapi			interval Between
IFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	a	DUE TO	OR AS A CON	SEQUENCE OF	for anter the m	ode of dying,	such as ca	rdiac or reapi			interval Between
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a b c d	DUE TO	OR AS A CON	NSEQUENCE OF	for anter the m	ode of dying,	such as ca	rdiac or reapi			interval Between
CER	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a b c d	DUE TO ((OR AS A CON	NSEQUENCE OF	not anter the m	cular Can	Such as ca	rdiac or reapi	AUTOPSY	24b. WE	interval Between
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CER	SHOCK, OF heart tell shock, of heart tell shock, of heart tell shock, of heart tell shock, of heart tell shock, of heart tell shock, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant cordinates the property of the p	a d d ONTRIB	DUE TO DUE TO DUE TO CONTRIBUTING TO CALL CONTRIBUTION 1 2 DE CONT	COR AS A CONCORD AS A CONCOR A	SEQUENCE OF DEAT	in the underlying the Check only one OTHER:	g cause gives UNCERT	n in Part I.	24a. WAS AN PERFOR	AUTOPSY MED?	24b. WE AMO CO' OF	Interval Between Onest and Death Clary Market State S
PHYSICIAN: MEDICAL CER	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions or conditions in death and conditions of the conditions of	a b c d ONTRIB	DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (COR AS A CON COR A	INSEQUENCE OF THE PROPERTY OF	in the underlying the Check only one OTHER: 4 Nursing Hor William Mills 1 1 1 1 1 1 1 1 1	g cause gives UNCERT DURY AT JURY AT	n in Part I.	24a. WAS AN. PERFORI	AUTOPSY MED?	24b. WE AMO CO' OF	Interval Between Onest and Death Clary Market State S
BY PHYSICIAN: MEDICAL CER	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant corditions of the condition of	b c d nditions c	DUE TO (DUE TO	COR AS A CON COR A	INSEQUENCE OF THE PROPERTY OF	in the underlying the Check only one. OTHER: 4 Nursing Hore E OF 28c. IN. W.	g cause gives UNCERT DURY AT JURY AT	TAIN 28d. Oth	24a. WAS AN. PERFORI	AUTOPSY MED?	24b. WE AME CO: OF 1 [Interval Between Onest and Death Clearly Manual Prince Programme Control of Cause Death? YES 2 NO
BY PHYSICIAN: MEDICAL CER	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant cordinates the cause of the condition of the cause of th	b c d c d ONTRIB CAL	DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (Morth, De Duilding, of Dui	(OR AS A CON OR AS A CON OR AS A CON USE OF D 26. P ER/Outpatlen INJURY (X Year) INJURY — A Inc. (Specify)	INSEQUENCE OF SECU	in the underlying the control of the	GREATER TO THE PROPERTY AT THE	n in Part I. [AIN] 28d. Oil 28f. LO	24a. WAS AN PERFORI 1 YES 2 CATION (Street e y or Town, State)	AUTOPSY MED? (NONO)	24b. WE AMM COOP 1 [Interval Between Onest and Death Clearly Manual Prince Programme Control of Cause Death? YES 2 NO
BE COMPLETED BY PHYSICIAN: MEDICAL CER	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant cores or injury that initiated events resulting in death) LAST DID TOBACCO USE Cores or injury that initiated events resulting in death) LAST DID TOBACCO USE Cores or injury that initiated events resulting in death) LAST DID TOBACCO USE Cores or injury that initiated events resulting in death investig and investig and investig and investig and initiated events resulting in death investig and investig and investig and investig and investig and investig and investig and investig and investig and investig and investig and investigation in the investig and investigation in the investigation in t	d	DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE DUE DUE DUE DUE DUE DUE DUE DUE DUE	(OR AS A CON OR A	SEQUENCE OF DEATH YE LACE OF DEATH INJURY IN DOME TO THE PROPERTY IN THE PROPE	in the underlying the control of the	g cause giver UNCERT The 5 Resider JURY AT YES 2 NO The and place, and death occurred at	TAIN Dart I.	24a. WAS AN PERFORI 1 YES 2 CATION (Street e y or Town, State)	AUTOPSY MED? (NONO AUTOPSY OCCI AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED. (NONO AUTOPSY MED. AUTOPSY MED. (NONO AUTOPSY MED. AUTOPSY MED. (NONO AUTOPSY MED. AUTO	24b. WE AMM COMO OF 1 [Interval Between Onest and Death Clary Market State Prior To Mapter Death? YES 2 NO
E COMPLETED BY PHYSICIAN: MEDICAL CER	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant contents of the condition of t	ONTRIB C d d d C d e	DUE TO (DUE TO (DUE TO (DUE TO (DUE TO ((OR AS A CON OR AS A CON OR AS A CON OR AS A CON OR AS A CON USE OF D 26. P ER/Outpatien INJURY (X Year) THIC. (Specify) Thy knowledge amination end	SEQUENCE OF SECUENCE OF SECUENCE OF DEAT	in the underlying the first of the time, dat the time, dat the time, dat the time, dat the time, in my opinion, description of the time, in my opinion, description of the time, in my opinion, description of the time, dat the t	g cause giver UNCERT UNCERT DURY AT DIRY AT DIRY AT DIRY AT DIRY AT 20C. LICENSE D 1 S	AIN Dart I. Zad. Ot 281. LO C/n due to the co	24a. WAS AN PERFORM 1 YES 2 CATION (Street e y or lown, State) RUSS(e) end men is and place, and	AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY OCCION AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY AUTOPSY MED. (NONO AUTOPSY MED. AUTOPSY MED. (NONO AUTOPSY AUTOPSY MED. AUTOP	24b. WE AMM COOP 1 [] COURS OF Aural Pouts d. Cause(s) and SIGNED (Mo	Interval Between Onest and Death Cleary Market States of the Control of the Control of Cause Death? YES 2 NO
BE COMPLETED BY PHYSICIAN: MEDICAL CER	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant cores or injury that initiated events resulting in death) LAST DID TOBACCO USE Cores or injury that initiated events resulting in death) LAST DID TOBACCO USE Cores or injury that initiated events resulting in death) LAST DID TOBACCO USE Cores or injury that initiated events resulting in death investig and investig and investig and investig and initiated events resulting in death investig and investig and investig and investig and investig and investig and investig and investig and investig and investig and investig and investigation in the investig and investigation in the investigation in t	ONTRIB C d d d C d e	DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (COR AS A CONCORDAN AS A CONCOR	SEOUENCE OF INSECUENCE OF INSE	in the underlying the first of the time, dat the time, dat the time, dat the time, dat the time, in my opinion, description of the time, in my opinion, description of the time, in my opinion, description of the time, dat the t	g cause giver UNCERT UNCERT DURY AT DIRY AT DIRY AT DIRY AT DIRY AT 20C. LICENSE D 1 S	AIN Dart I. Zad. Ot 281. LO C/n due to the co	24a. WAS AN PERFORM 1 YES 2 CATION (Street e y or lown, State) RUSS(e) end men is and place, and	AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY OCCION AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY MED? (NONO AUTOPSY AUTOPSY MED. (NONO AUTOPSY MED. AUTOPSY MED. (NONO AUTOPSY AUTOPSY MED. AUTOP	24b. WE AMM COOP 1 [] COURS OF Aural Pouts d. Cause(s) and SIGNED (Mo	Interval Between Onest and Death Cleary Market States of the Control of the Control of Cause Death? YES 2 NO



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
THE OL	TO THE be filed	IMPOR	100

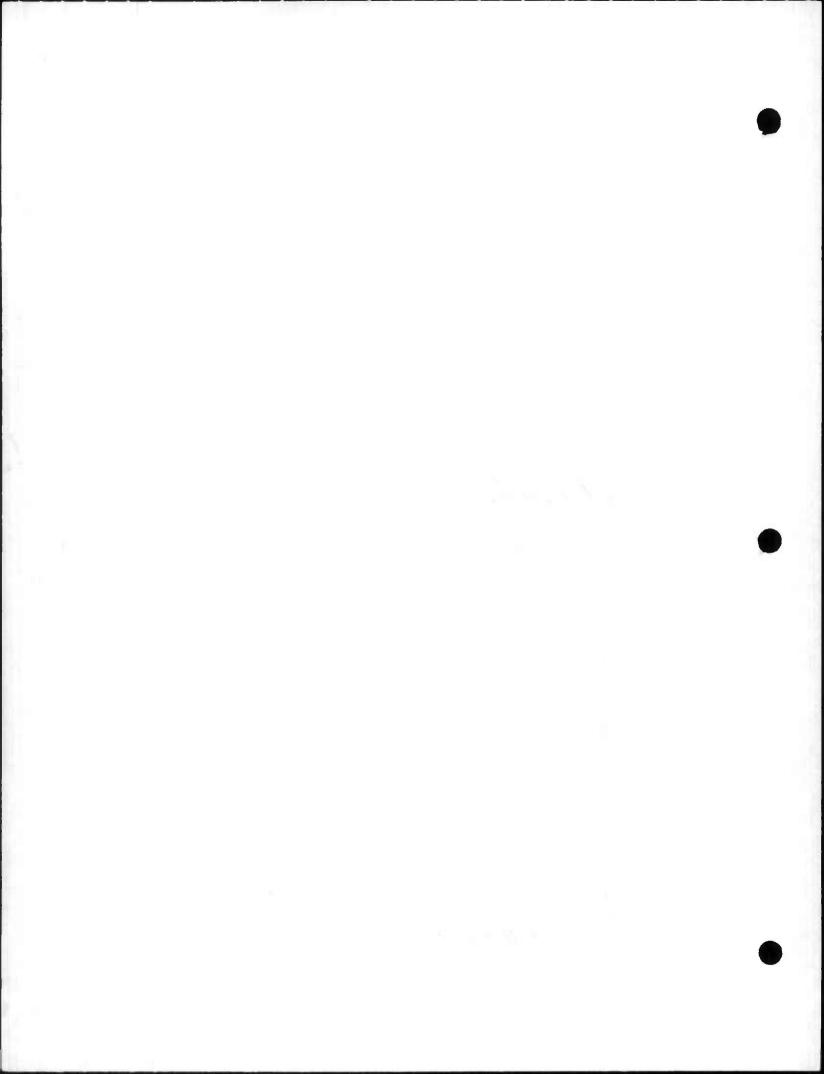
	FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H			YGIENE	E				
	1. OECEOENT'S NAME (First, Middle, Last)	0.112 0.	2. DATE OF OFATH 3. TIME OF OF					. TIME OF OEATI	н			
	HENRY HARO			FEBRUA	ARY 2	24,1995 12:30 P.						
	4. SOCIAL SECURITY NUMBER	IF UNDER 1 YEAR	YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. B					ACE (State or For				
	142–12–7157 90. FACILITY NAME (If not institution, give str	2-7157 1 X M 2 U F 98 YRS. 1 1 1 1 SEPT 29						96, COUNT	NEW	YORK		
DIRECTOR	MERIDIAN NURSING		SILVER SPRING				MONTGOMERY					
SEC.	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT			10	Od. INSIDE CITY	_			
	FLORIDA PALM]	ВЕАСН	WES		PALM BEACH 101. ZIP COOE					YES 2 A	NO	
FUNERAL	STRATFORD K-143		33417					TATES				
5	11. MARITAL STATUS	12. WAS DECEOENT EVER IN		13. WAS DEC	ENOENT OF HISPAI	NIC ORIGIN? (S	pecify Yes			- American Indie	n.	
	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp	2 X NO Specif	en, Puerto Rica	n, etc.)	1,112	Black, V Specify:	White, atc.		
D BY						,				HITE		
COMPLETED	15. DECEDENT'S EOUC. (Specify only highest grade of	ATION :ompleted)	16a. OECEDENT'S U (Give kind of w life. Do NOT use	ork done during mo	ON st of working	16b. KIN	O OF BUSI	INESS/INOU	STRY			
7	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4 or 5+)					INSURANCE					
N N	17. FATHER'S NAME (First, Middle, Last)		BROKER	-	18. MOTHER'S NA	ME (First Address			CE			
	SAMUEL NUSSBAT	DM .			ROSE	FILI		iumame)				
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO	AOORESS (Street e	nd Number or Rural			State 7in C	Corde			
입	BERTRAM NUSSBAUM	(SON)			L DRIVE,					08816		
	20e. METHOD OF DISPOSITION 1X Burial 2 Credition 3 Remove 4 Donation 5 Option (Specify)	val from State 20b.1	PLACE AND OATEO	FOISPOSITION (Na per place) MEMORTAT	me of	OATE 5 2/26	20c. LOC.	ATION — CI	ty or Town	, State		
	21. SIGNATURE OF THERAL SERVICE CICE	NSQ.	O DIDLINE.	22. NAME AN	O AOORESS OF FA	CILITY						
	· 41.	To H	-		SKY-GOLD							
	23. PART i. Enter the diseeeas pr co	molications that caused	the death Do no	111/0 R	OCKVILLE	PIKE	- RO	CKVIL	LE,MI			
	snock, or naert failure. Li	lat only one ceuse on ee	ch line.	ot amar the mo	oa or dying, suc	n sa cardiac	or reapin	atory arres	st,	Approxima interval Be		
	disease or condition resulting in death) s. MALNUTIZITION								Onset and	12000		
	resulting in death) s.	OHE TO JOB AS A									45	
Z	Samue Malle Viet and Malle D.		WEEK					5				
CERTIFICATION	Sequantielly list conditions, if sny, laading to immediata	OUE TO (OR AS A	CONSEQUENCE OF):						111/70	- (
<u> </u>	CAUSE (Disesse or injury	CHICOI	OUE TO (OR AS A CONSEQUENCE OF): INANITION OUE TO (OR AS A CONSEQUENCE OF): CHRONIC NAUSEA & Epigastric Pain WE OUE TO (OR AS A CONSEQUENCE OF): DEPRESSION WE						WEEK	رــ		
Ē	that initiated events resulting in death) LAST	LEGO J	CONSEQUENCE OF	: ^/		V				W)FFT	10	
	d.									10000	~ .	
ÄL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AI									ERE AUTOPSY FIN		
음Ⅱ	TO VES OF A STAND COM									MILABLE PRIOR TO DMPLETION OF CA F DEATH?		
MEDIC							/			YES 2 N	0	
ÿ	DID TOBACCO USE CONTRI	IBUTE TO CAUSE OF	DEATH YES	NO 🗵	UNCERTAIN	NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF OEATH	(Check only one)								
<u>s</u>		1 Inpatient 2 ER/Outpat	tlent 3 DOA		5 - Residence	6 Other (Sp	ecify)	_				
	1 Natural 5 Pending	(Month, Day, Year)	26e. OATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY			WORK?		OW INJURY OCCUREO				
à I	2 Accident investigation	284 PLACE OF IN HIRY	M M			I YES 2 NO						
ETED	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Specify	OF INJURY — At home, ferm, street, fectory, office g, stc. (Specify)			261. LOCATION (Street end Number or Rurel Route Number, City or Town, State)						
Z	CERTIFIER (Check only 1 CERTIFVINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end manner as stated.											
COMPL	one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner as stated.											
w II	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER			29d. DATE S	IGNEO (Mc	onth, Day, Year)		
0	KOBERT H.	KNITZER			D 3793	30		2	1241	95		
ĭ	30. NAME AND ADDRESS OF PERSON WHO ISILL PRINCE P		TH (ITEM 27) (Type, F		VEY	MO	-	208	スフ			
ŀ	31. DATE FILEO (Month, Day, Ybar)	22. SEGISTRAR'S SIGNAT	UME_		17			0	1		_	
	FEB 27 1995	John Davidson	Revolate									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR 1 - STATE REGISTRAR	STATE (F MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH
Dorothy	B	Nouton	MONTH DAY

	1. DECEDENT'S NAME (First, Middle, Lest) Dorothy B. Newton February 28 1995									3. TIME OF DEATH		
	Dorothy	Newton						February 28, 1995			6:45 A M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) FUNDS TO M 2 2 F 86 YRS. MONTHS					DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) Oct. 28, 1908 Nebraska				(1/1)
R	9a. FACILITY NAME (If not institution, Home Care Faci				96. CITY, TOWN OR LOCATION OF DEATH Derwood Montgome							
5	RESIDENCE OF DECEDENT				DCI	woo	<u> </u>			Hon	Lgoill	ery
DIRECTOR	Maryland Mon		10c. CITY, Sil		Spr						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	3355 S. Leisure	World Blvd	•	101. ZIP CODE 20906				10g. CITIZEN OF USA			USA	WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2 2	RMED NO		If yes, sp	ENDENT OF HISPAI ecify Cuben, Mexica 2 XNO Specific	an, Puerto	IN? (Specify Ye Ricen, etc.)	e or No-	14. RACI Blaci Spec	E — American Indian, k, White, atc. //y: White
유	15. DECEDENT'S (Specify only highest		16a. Di	CEDENT'S	SUAL O	CCUPATIO	ON	16	b. KIND OF BU	JSINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	- In	(Give kind of work done during most of working life. Do NOT use natired.) Supervisor					1	RS			
Š	17. FATHER'S NAME (First, Middle, Las	1)		C.			16. MOTHER'S NA	AME (First,				
BE C	Fred Russell						Unobta			,		
8	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street e	and Number or Rural			vn, Stele, Zi	p Code)	
임	Randolph Newton	n										aryland 2081
	20s. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3		001 01 100						10.00			
	4 Donation 5 DOther (Specify)	$-\lambda$	Co Lum	bia G	er place) arde	ens	Cemetery	3/	4 Ar1	ingto	on. V	Virginia
- 1	21. SIGNATURE OF YUNERAL SERVICE		22.	NAME AN	ND ADDRESS OF FA	CILITYH	ines-R	inal	ii Fu	Virginia Ineral Home		
- 1	> Khilis XI	Musld.							TTC IIA	CIICC		
\neg	Silver Spring, Maryland 20904 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	ahoca, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel											
	disease or condition											
	resulting in death) Myocardial Infarction Due to (DR AS A CONSEQUENCE OF):								Immediate			
_	Atherosclerosis									30 Years		
흔	Sequentially list conditions, If any, leading to immediate b. Attretoscietosis Due to (or as a consequence of):									30 lears		
₹	cause. Enter UNDERLYING CAUSE (Disease or Injury											
	that initiated events	DUE TO (C	OR AS A CONSE	QUENCE OF)								
CERTIFICATION	resulting in death) LAST	resulting in death) LAST										
	PART II. Other algnificant cond	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS										
5				_		,			PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL									1 TYES	2 <u>P</u> NO		OF DEATH?
	DID TOBACCO USE CO	NTRIBLITE TO CALL	ISE OF DEA	TH VEC		IO F	LINICEDTAI	N D				1 WES 2 NO
N N	25. WAS CASE REFERRED TO MEDICA			E OF OEATH			UNCERIAII	N				
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER		. C Doubles	. M		Iome	Care	Facility
H	27. MANNER OF DEATH	28e. DATE OF III	JURY	28b. TIME	OF	28c. INJ	URY AT		SCRIBE HOW			ractificy
_	1 Natural 5 Pending	(Month, Day,	Year)	INJU	RY M	WO	RK? res 2 No					
8	2 Accident Investigat 3 Suicide 8 Could no	28e. PLACE OF		me, farm, str	reet, tacto			28f. LO	CATION (Street	end Numbe	r or Rural F	Route Number.
<u> </u>	4 Homicide determine		c. (Specify)						or Town, State			
COMPLETED		HYSICIAN: To the best of m										
20 25	Klern G.	N. lale	ν,	M.			D04	179		29d. DAT	Lar.	2,1995
-	30. NAME AND ADDRESS OF PERSON			, , ,, ., .		110) F - C'					
	Kevin G. Nealon,	M.U. 5530	wiscon	sin A	ve.,	#92	25, Chev	y Ch	ase, M	aryla	and 2	20815
	MAR 03 1995	July Divole	randy									
												DHMH-16 Rev 1/6



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fire death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

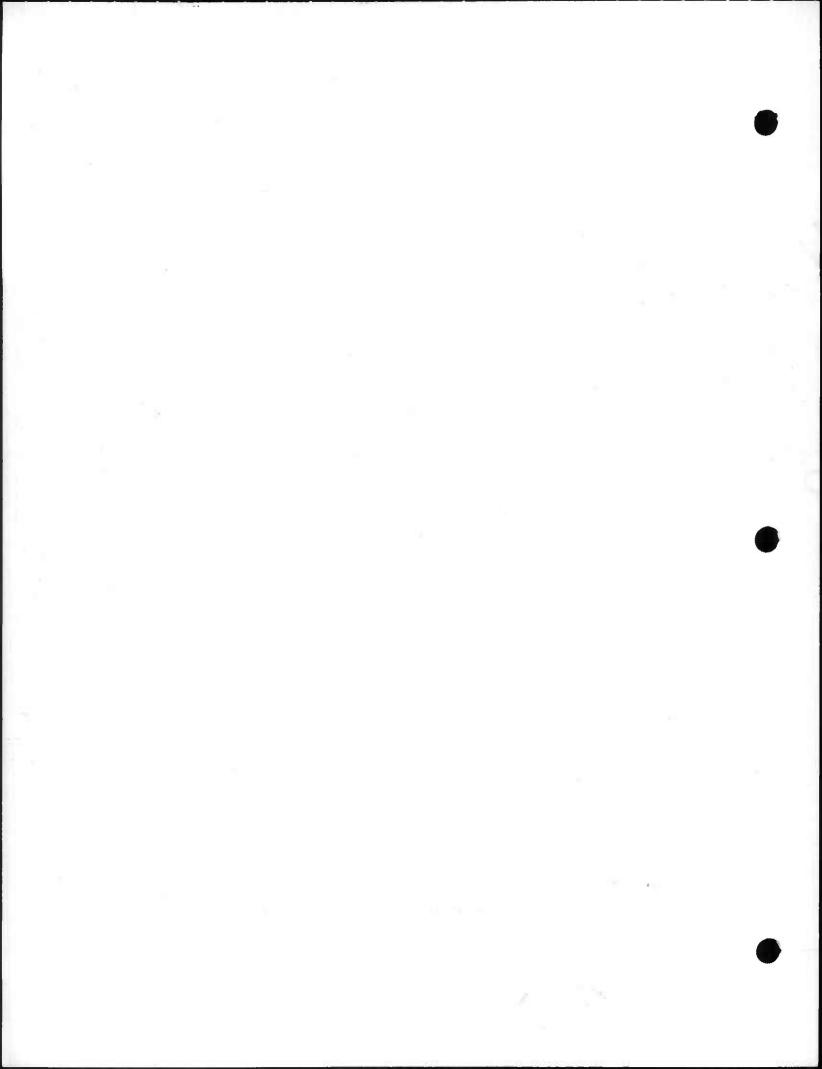
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

					OLIT	11 107	TIE OI	DEA			HEG. NO.			
	1. DECEDENT'S NAME (First, James	Middle, Last)		Norton	n						2. DATE OF DEATH MONTH MArch 2, DAY 1995			3. TIME OF DEATH 7:30 A. M
	4. SOCIAL SECURITY NUMBE	ER	5. SEX	8. AGE (In y	rs. last birtho	(av) IF (JNDER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF				PLACE (State or Foreign
	201-03-8224		1 XM 2 - F	80		, MON	V	HOURS	MIN.	(Month, I	(Month, Day, Year) Country			sylvania
	9a. FACILITY NAME (If not institution, give street and number)						CITY, TOWN	OR LOCAT	ION OF D			_	INTY OF DI	
DIRECTOR	1009 Lewis A						Rockville					Mc	ontgo	mery
ပ္ပ							WH OR LOC	ATION						
	Maryland		Montgome	ery	1000	011, 10		Rockv	ille				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
₹	10e. STREET AND NUMBER				1	of. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?		
LONGHAL	1009 Lewis A	venue						208	51			Uni	ted S	tates
5	11. MARITAL STATUS	V-1000	12. WAS DECEDEN FORCES? 1				13. WAS DE	CENDENT	OF HISPA	NIC ORIGIN? (an, Puerto Ric	Specify Yea	or No-	14. RACE	— American Indian, White, aic.
5	1 Never Married 2 X h 3 Wildowed 4 Divort		World	WAR OR DATE	s			S 2 X NO			en, etc.)		Specif	
COMPLEIED	15. DECE (Specify only	DENT'S EDUC	ATION		e. DECEDEN	T'S USU	AL OCCUPAT done during n	ION rost of worki	ing	16b. K	IND OF BUS	BINESS/IN		1.00
	Elementary/Secondary (0-1	12)	College (1-4 or 5							G	overni	mont		
5	17. FATHER'S NAME (First, Mic	17. FATHER'S NAME (First, Middle, Last)				Planning Engineer 18. MOTHER'S NAME (First,								
		Norton	1					16. MOI		llian		,		
i o	19a. INFORMANT'S NAME (Typ				19b. MAII	ING ADD	RESS (Street	and Numbe		Route Number,			in Code)	
2	Joseph J. No	rton								, Dama				72
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Ramoval from Stala 4 Donation 5 Other (Specify) Arlingto					or other n	lece)				1		City or Tov	vn, Stata 'irginia
	4 Donetion 5 Other (Specify) Arlington 1 21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Fune						ev Funeral	
	Home/Rockville, Inc., 300 W. Mont Rockville, Maryland 20850-2805							tgomery Av						
	23. PART I. Enter the dis	eesee, or co art feliure. L	omplications the list only one cau	t caused th	e deeth. D	o not e	nter the m	ode of dy	ing, aud	h es cerdie	c or reepi	ratory ar	rest,	Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition									Onset and Death				
	resulting in death) Emphysema Due to (or as a consequence of):									3 years				
-														
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING													
3	CAUSE (Disease or injury		DUE TO	(OR AS A CO	NSFOLIENC	F OF								
MEDICAL CENTIFICATION	resulting in death) LAST	d				- 0. ,.								į
	PART II. Other significan	t conditions	contributing to	death but i	not resulti	no in the	e underivis	on ceuse	niven in	Part I 2	ta. WAS AN	ALITOREY	245	WERE AUTOPSY FINDINGS
	Congestive					g	o unacriyii	ig couse i	given in	- 1	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Myocardial	Infaro	tion							_ '	YES 2	Μ		OF DEATH?
	DID TOBACCO US			USE OF E	DEATH	YES 5	ON	JUNG	ERTAI	N 🗆				I LES Z X NO
	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL				EATH (C)	neck only one							
	1 X YES 2 □ NO		HOSPITAL:	ER/Outpatie	nt 3 🗆 DO		HER: Nursing Ho	me 5 XR	esidence	8 Other (S	Specify)			
	27. MANNER OF DEATH		28a. DATE OF (Month, D		28b.	TIME OF		JURY AT ORK?		28d. DESCR	IBE HOW IN	JURY OC	CURED	
	1 🔀 Netural 5 🗌 Pi 2 🗍 Accident In	ending vestigation					M 1 🗆	YES 2	NO					
		ould not be etermined	28e. PLACE O building,	F INJURY — I etc. (Specify)	At home, far	m, street,	tactory, offi	ca			LOCATION (Street and Number or Bural Route Number, City or Town, State)			
			IAN: To the bast of											and manner as stated.
	29b. SIGNATURE AND TITLE C										1			
1 / hus to () 1 March 2 1995														
	30. NAME AND ADDRESS OF	/ /		SE OF DEATH	(ITEM 27) (
	Christopher	/	ford, M			Mon	tgome	ry Av	enue	, Rocl	kvill	e, M	D 208	350-3815
	31. DATE FILED (Month, Day, Ye		32. REGISTRA											

DHMH-16 Rev 1/89



OHMH-16 Rev 1/89

Pages 1, 2, 3 should

use as the burlal-transit permit.

detached for

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page 5 should

funeral director,

this certificate has been signed by the attending physician and completely filled in by the virth the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIRECTOR: After the hours after death v

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VITAL F	The
OF VI	TENDING PHYSICIAN:
DIVISION	ATTENDING
	R
	HOSPITAL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 02-23-95 6:40PM CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) Dorothy Sames Owens 2. DATE OF DEATH MONTH 3. TIME OF OEATH 840 wens 2 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Maryland 218-09-1483 1 M 2 📆 YRS. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Lothian Anne Arundel 1 YES Z NO 10e, STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 5893 Pindell Road United States 20711 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. 1 Never Merried 2 Merried If yes, specify Cuber, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY ₩ Widowed 4 Divorced White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Broker Real Estate 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Frank Sames notified at Nell Harrington BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Janet S. Owens 1272 Indian Landing Road Millersville, MD 21108 must be 20a METHOD OF DISPOSITION

AND Burlel 2 Cremetion 3 Removal 20b. PLACE AND DATE OF DISPOSITION (Name of 2/27/95 DATE 20c. LOCATION - City or Town, State St. James Episcopal Church Cem Lothian, Maryland 4 Donation 5 Other (Specify) traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I/Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Intarval Batween Onset and Death IMMEDIATE CAUSE (Final 0 disesse or condition resulting in death) A CONSEQUENCE OF CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immedista cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL shows any 1 TYES 2 TUNO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO | 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem OTHER: 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 | KNatural 1 YES 2 NO BY 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, 1erm, street, 1actory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide tem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If Its 2 MEDICAL EXAMINER: On the estigation, in my opinion, desth occured at the time, date and place, and due to the cause(a) and manner so stated 29c. LICENSE NUMBER put BE 060 9 LETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year)

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4	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the	
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		1 - STATE REGISTRAR	STATE OF I	MARYLAN	D / DEPAR CERTIF	ICATE	OF DE	TH AND N ATH	IENTAL HYGIEN REG. NO	_		
		1. DECEDENT'S NAME (First, Middle, Last) WANDA	A CATHER		O'NEIL				2. DATE OF DEATH DO DO DO DO DO DO DO DO DO DO DO DO DO	AY	3. TIME OF DEATH ON 40 M	
		4. SOCIAL SECURITY NUMBER 045-14-1597	5. SEX 1 M 2 X F		s. last birthday) YRS.	IF UNDER 1	EAR IF U	NDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) May 12 192	1 4	BIRTHPLACE (State or Foreign Country) Connecticut	
, 3 should	OR	90. FACILITY NAME (If not institution, give a		pital		9b. CITY, TOWN OR LOCATION OF DEATH Cambridge Dorchester						
7,	5	RESIDENCE OF DECEDENT										
if. Page	DIRECTOR		chester		10c. CIT	y, town or Hur	10d. INSIDE CITY LIMITS? 1 YES 2 NO					
insit pern	FUNERAL	100. STREET AND NUMBER 6209 Palmers	Mill Rd.			101. ZIP COOE 21643 10g. CITIZEN OF WHAT U.S.A.						
mecoo., page 3 should be detached for use as the burlan-transk permit. Pages 1, 2, 3 should if must be notified at once.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	X NO	I1 y	es, specify (NT OF HISPANI Cuben, Mexicen NO Specify:	C ORIGIN? (Specify Yee Puerto Rican, etc.)	or No-	e. RACE — American Indian, Black, White, etc. Specify: White	
	COMPLETED		(Specify only highest grade completed) (G Elementary/Secondary (0-12) Collega (1-4 or 5+)				DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker					
	BE COM	t7. FATHER'S NAME (First, Middle, Last) Victor		16. MOTHER'S NAME (First, Middle, Meiden Surneme) Katherine Gombrewicz								
	10	Margaret O. Nick	cles		196. MAILING 11830	Lind	en Ch	mber or Aural Ro apel R	d., Clarks	n, State, Zip C SVille	MD 21029	
		20e. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Ram 4 Denetion 5 Other (Specify)	ovel from State	Our Our	Lady G	ther place)	on(Name of	1 Chur	oate 20c. Lo	cation – cir	cretary Md.	
or removal. medical examiner			22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St., Cambridge MD 21613 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
		23. PART i. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	NAC	Ilna.	lot entar th	a mode of	dying, such	as cardiac or respi	retory arres	Approximate interval Between Onset and Daath	
for to buria	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that iolitisted events). DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									YR5	
and Mental Hygiene pr ny Injury, or other t	ERTI	that initiated events resulting in death) LAST d										
State Dept. of Health and Menta item 23 shows any injury,	MEDICAL	PART II. Other significant condition	13//	m/	100	PD	7	VL)	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO	
Dept.	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA		PLACE OF DEAT			NCERTAIN	X			
State Item	SICI	EXAMINER?	HOSPITAL:			OTHER:		7.5				
r death with the is marked, or	ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF (Month, D	INJURY	26b. TIM	E OF 26 URY	c. INJURY A' WORK?	т	Other (Specify) 26d. OESCRIBE HOW 1	NJURY OCCU	REO	
after 28 i	ETED B	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE O building,	F INJURY — A etc. (Specify)	it home, ferm, a	tree1, fectory	office		261. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,	
ANT: If item	COMPLE		R: On the beels of e								cause(e) end menner as stated.	
be filed within 72 t	O BE	296. SIGNATURE AND WILE OF CENTIFIER	M.	D. (0.		29c.	4446	5	29d. DATE S	GIGNED (Month, Day Year)	
		TOI	o completed caus s Narr, I			Print) 08 By1	n Str	ceet	Cambridge	, MD	21613	
		FFB 2 7 1995	32. REGISTRA	R'S SIGNIOUR	dall							

1. OFCEGENT'S NAME (First, Middle, Last)

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permit. Pages 1, 2, 3 should

retained by the hospital or attending physician. 5 should be detached for use as the burial-transit

BALTIMORE, MARYLAND 21203-3146

DIRECTOR

FUNERAL

BY

COMPLETED

BE

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CERTIFICATION

MEDICAL

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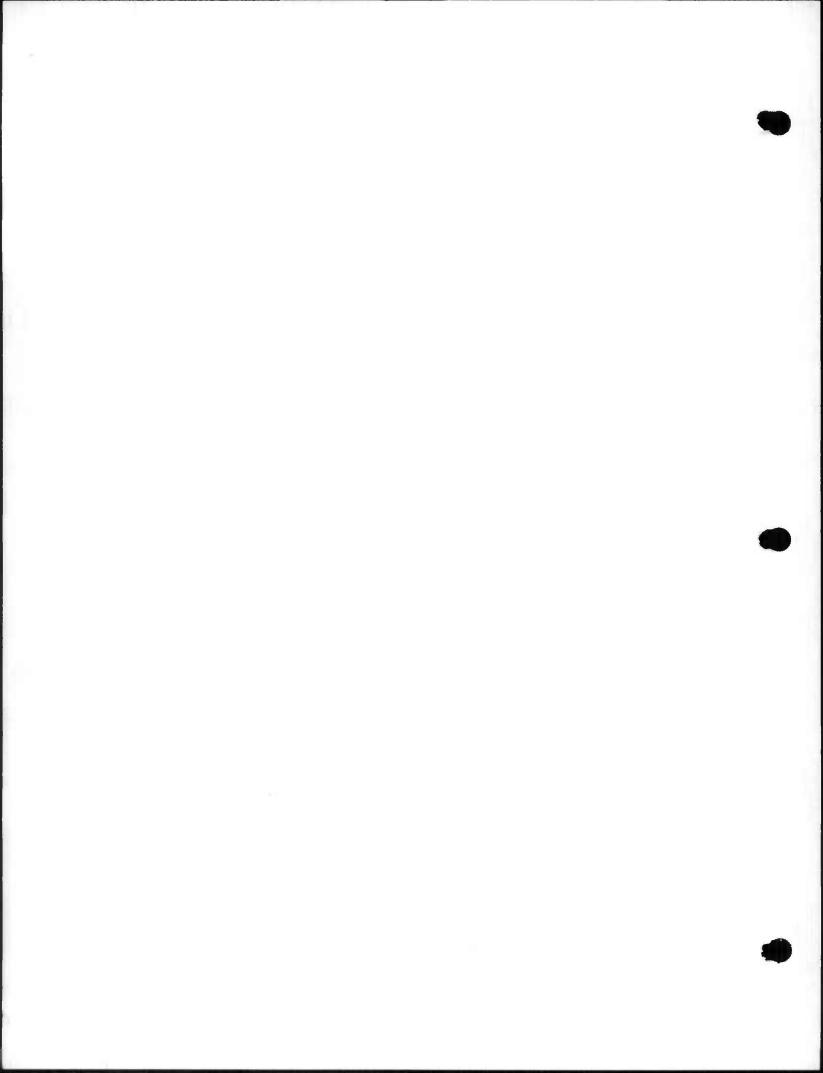
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely must in by the funeral director,		IMPORTANT If Item 28 is marked or item 23 shows any Injury or other traumatic event, the medical examiner mus
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WITHIN	pletely	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ent. t
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2. DATE OF DEATH MONTH 3. TIME OF DEATH rher 8 EVELYN 02 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 7 DATE OF BIRTH 6. BIRTHPLACE (State or Foreign HOURS 339-03-2040 1 M 2 X F 77 26. Virginia August 1917 9s. FACILITY NAME (If not institution, give street and number) 95 CITY TOWN OR LOCATION OF DEATH Re. COUNTY OF DEATH Manor Care Silver Spring Montgomery RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 TES 2 1 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 405 Hillmoor Drive 20901 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. ORCES? 1 YES 2. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 X Married Specify: White 3 Widowed 4 Divorced 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Varn P. Hambright Mary C. Henderson 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodrow D. Orner 405 Hillmoor Drive Silver Spring, MD 20901 20s. METHOD OF DISPOSITION
1 □ Burlel 2 1 Cremetion 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory of State place) 20c. LOCATION — City or Town, State 595Alexandria Virginia Metropolitan Crematory 21, SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, 500 University Blvd.W. Sil.Spr. M MD 20901 23. PART L'Enter the diseases, or complications that caused the death. Do not enter the mods of dying, auch as cardiec or respiretory street, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Finel** disease or condition OF OTATY Grey
OUE TO (OR AS A CONSCOUENCE OF): recuiting in deeth) Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, lesding to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Demenha. AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES ANO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER:
4 Nursing Homs 5 Residence 6 Other (Specify) HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 26c. INJURY AT WORK?
1 YES 2 NO 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28d. DEŞCRIBE HOW INJURY OCCUREO 28b. TIME OF 1 Accident 5 Pending 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be datermined 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 36. NAME AND ADD SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 14353 Laure JOHN MARGOLIS 31, DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 27 1991



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Nours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

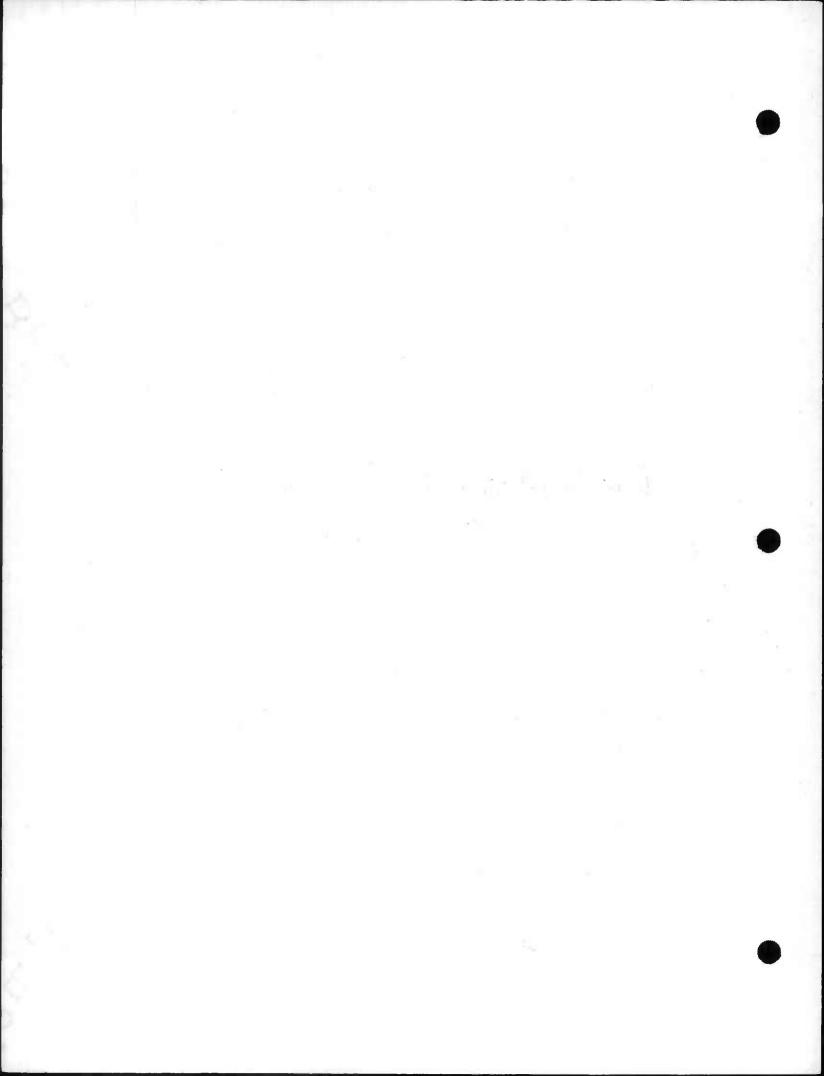
REGISTRAR				OF DEATH		REG. NO				
1. DECEDENT'S NAME (First, Middle, Last)			Nei 1/		2. DATE OF	2. DATE OF DEATH MONTH DAY YE			3. TIME OF DEATH	
			Neill		Marc	_		1995	8:05 P M	
4. SOCIAL SECURITY NUMBER	-3.70	E (In yrs. last birthday)	MONTHS DA		7. DATE OF (Month, D	BIRTH av. Year)		8. BIRTH Countr	IPLACE (State or Foreign	
215-10-5526	1 XM 2 - F	79 YRS.	MONTHS (M	TS HOURS MIN.	July	22	1915	Ma	ryland	
9a. FACILITY NAME (If not institution, gi			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
Howard County (tal	Colu	mbia			F	lowar.	d	
10a. STATE 10b. COU		10c, CITY	, TOWN OR LO	CATION					104 INSIDE CITY	
Maryland Ho	oward		licott						10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
10e. STREET AND NUMBER				10f. ZIP CODE			10g, Cf1	IZEN OF V	WHAT COUNTRY?	
5004 Waterloo Ro	oad			21043			133	U.S.		
11. MARITAL STATUS	12. WAS DECEDENT EYER FORCES? 1 XYE	IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Yea	or No-	14. RACE	— American Indian,	
1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES GIVE WAS OR			yes 2 NO Specific		in, etc.)		Speci		
15. DECEDENT'S E	DUCATION	18a. DECEDENT'S I	USUAL OCCUP	ATION	16h KI	ND OF BUS	DIMESS /IM	DUSTRY	WILLCE	
(Specify only highest gr Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during	most of working	100. KI	ND OF BUS	SINE SS/IN	DUSTRE		
0-12	Conege (I-4 or 5+)	Carpent	ter							
17. FATHER'S NAME (First, Middle, Last)		~		18. MOTHER'S NA	ME (First, Midd	tle, Maiden	Sumame)			
John F. O'Neil]				Bessie	e DeGra	aft				
19a. INFORMANT'S NAME (Type/Print)				et and Number or Rural						
Mary M. O'Neill				oo Rd.,Ell		_				
1 Donation 8 Other (Specify)	amoval from State	ob. PLACE AND DATE O	F DISPOSITION Per place)		0ATE 3/7/95			city or To		
21. SIGNATURE OF FUNERAL SERVICE									٠.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HARRY H. WITKZE FUNERAL HOME 4112 Old Columbia Pike, Ellicott City 21043										
23. PART I. Enter the diseases, of	or complications that cause	ed the desth. Do no	ot enter the	mode of dving, suc	th as cardiac	LKE, E	TTTC	Teat	Approximate	
shock, or heeft fellui	e. List only one ceuse on	sech lins.		,,				,	Interval Batween	
IMMEDIATE CAUSE (Finel disesse or condition		SEDRIC	,						Onset and Daath	
resulting in death)	eDUE TO (OR AS	A CONSEQUENCE OF):						- 404y	
	- RESPIL	PATTORY	FA	ILURE					52 da	
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):						7	
CAUSE (Disease or Injury	. OtRovie	6 BSTRO	LCTIV	e PULM	EWARY	P	150	ASE	7 20 year	
that initieted events resulting in deeth) LAST	DUE TO (OR AS	A CONSEQUENCE OF):							
resulting in deeth) LAST	d									
PART II. Other eignificant condit	lons contributing to deeth	but not resulting in	the underl	ying cause given in	Part I. 24	a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS	
Cancino		ostate				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
Atherosclerot	- 1	Vercelas	Dise	Lase	_ '	YES 2	NO		OF GEATH?	
DID TOBACCO USE CON					ΝП				1 TYES 2 NO	
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF GEATH				-	_			
EXAMINER?	HOSPITAL:		OTHER:	fome 5 Residence	8 Other (Si	pec/fvl				
27, MANNER OF OEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c.	INJURY AT	28d. DESCRI		NJURY OC	CURED		
Natural 5 Pending 2 Accident Investigatio		INJU		WORK? YES 2 NO						
3 Suicide 8 Could not t	28a. PLACE OF INJUIE	tY — At home, term, at	reet, factory, o	office	281. LOCATIO	ON (Street e	nd Numbe	r or Rural R	oute Number,	
4 Homicide determined					City of R	own, State)			4	
290. CERTIFIER 1 CERTIFYING PH	YSICIAN: To the beat of my kno	wledge, death occurred	d at the time, o	date and place, and due	to the cause(i	a) and man	ner aa ata	ted.		
296. SIGNATURE AND TITLE OF CERTIF	FIER N			29c. LICENSE NUI					(Month, Day, Year)	
1. B. 46.0	anto			D - 30)469		▶ IV	larch	3, 1995	
30. NAME AND ADDRESS OF PERSON Nandakumar Vell	who completed cause of a anki, M.D.	9055 Chevi	rolet]	Drive #100) E11:	icott	Cit	y, M	D 21042	
31. DATE FILE MAR 20 16 199	32-TRICLIETT AIR'S SIG	sockardall								

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Flours after death. Page 6 may be retained by the hospital or attending physician.	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN	TO THE FUNERAL DIRECTOR: After this certific be filed within 72 hours after death with the S	IMPORTANT: If item 28 is marked, or I	

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) Kathleen	Marie	O'Rourl	70		2. DATE OF DEATH	7 100	3. TIME OF DEATH 6:15 A M	
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			
	218-50-0530	1 □ M 2 🎇 F	89 YRS.	IONTHS DAYS	HOURS MIN.	May 16, 1	905	BIRTHPLACE (State or Foreign Country) MD •	
OR	96. FACILITY NAME (If not institution, give s Memorial Hospital	. & Medical C	Center	Cumber	or location of deal	АТН	sc. county of DEATH Allegany		
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	1000	TOWN OR LOCAT					
DIRECTOR		egany		berland				10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	garry	Cui		. ZIP CODE		I son CITIZEN	1 X YES 2 NO	
FUNERAL	438 Chestnut S				21502		USA		
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 M Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DEC	WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee If yes, specify Cuben, Mexican, Puerto Rican, etc.) YES 2 NO Specify:			RACE — American Indian, Black, White, etc. Specify: White	
	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S U	SUAL OCCUPATION MORE	ON .	16b. KIND OF BU	SINESS/INDUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOI use	retired.)	a www.mg				
PA	17. FATHER'S NAME (First, Middle, Last)		Manag	<i>j</i> er		School		eria	
	Robert B. Cunni	ngham				M. (Hald			
BE	19a. INFORMANT'S NAME (Type/Print)	11912cm	19b, MAILING A	DDRESS (Street e		oute Number, City or Tox		del	
2	Mary Keller					erland, M			
	20e. METHOD OF DISPOSITION 1X Burial 2 Cremellon 3 Rem 4 Donallon 5 Other (Specify)		PLACE AND DATE OF DETERMINED TO STATE OF THE DUNSET MEN	DISPOSITION (Na	ime of	DATE 20c. LC	CATION — City	or Town, State	
	21. SIGNATURE OF FUNERAC SERVICE LIC		I//			ww Kight			
	· William	15 King	AD .					nd, MD. 21502	
ATION	23. PART i. Enter the diseases, or complications that consend the desth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only and cause in each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)								
CERTIFICATION	CAUSE (Disease or Injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF) d.								
	PART II. Other algolificant condition	s contributing to death b	ut not resulting in	the underlying	g cause given in F	Part I, 24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
MEDICAL						1 YES	NO NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	DID TOBACCO USE O	ONTRIBUTE TO	CAUSE OF	DEATH Y	ES NO	TX1 /		1 TYES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL				ACE OF DEATH (Chec	/		L	
SIC	1 VES 2 NO	HOSPITAL:		OTHER:	e 5 🗆 Residence 8				
Y PHYSICIAN:	27. MANNER OF BEATH 1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	OF 28c. INJ WO		28d. DESCRIBE HOW	NJURY OCCUR	ED	
ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, lerm, atr	eet, lectory, office	•	281. LOCATION (Street City or Town, State	end Number or i	Rural Route Number,	
COMPLETED		CIAN: To the best of my know	ledge, death occurred	at the time, date	end place, end due t	o lhe cause(e) end ma	nner ee stated.		
Ö	one) 2 MEDICAL EXAMINE	fi: On the beele of exemination	n end/or investigation,	In my opinion, d	eath occured at the I	ime, date end place, er	nd due to the co	euse(e) end menner es stated,	
BE	29b. SIGNATURE AND TITLE OF COMPUTE	in W)			D 1604		29d. DATE SI	GNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P	rint)	D 1004		7	X/ /U	
	Dr. T. Williams,	Memorial Ho	spital Me	dical E	Building,	Cumberla	nd, MD.	21502	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAP'S SIGN	ATURE .						
	MAD 0 2 1995	green Museum							



ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/9/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH WILLIAM ANTHONY PROCTOR FEB 1995 6:20 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7 DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. inth, Day, Year, 8. BIRTHPLACE (State or Foreig 219 34 7690 1 M 2 | F 56 YRS. Feb. 1939 Maryland should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Bowie XX YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3029 Northdale Lane use as the burial-transit 20716 United States retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Ri 1 YES MENO Specify: BY 3 Widowed 4 Divorced Black ETED. 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe 12 funeral director, page 5 should be detached for College (1-4 or 5+) COMPL Security Guard Doctors' Community Hospital 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) To Leonard Proctor Effie Blake BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gail Proctor 3029 Northdale Lane Bowie Maryland 20716 death. Page 6 may be e 20a. METNOD OF DISPOSITION
1X PBurlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must Jones Cemetery 2/25/95 4 Donation 5 Other (Specify) Bowie Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A. over 16000 Annapolis Rd. Bowie Md. 20715 and completely filled in by the burial, cremation, or removal. hours after medical 23. PART i. Enter the disesses, or complications that ceuced the deeth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, **Approximate** shock, or heart failure. Liet only one ceuse on each line. Intervsi Between 0 **IMMEDIATE CAUSE (Fine)** Onset and Death the disease or condition ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (DR AS A CONSEDUENCE OF): executed traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): 2 the death certificate be attending physician tal Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST 9 the atter PART ii. Other significent conditione contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY n signed by the Health and I that YES 2 NO OF DEATH? 1 TYES 2 NO L. of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 3W has b 25. WAS CASE REFERRED TO MEDICAL The 26. PLACE OF DEATN (Check only one) certificate to the State HOSPITAL OR ATTENDING PHYSICIAN: OTHER: 1 X YES 2 - NO 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Home 5 ☐ Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this with 1 XXNatural 5 Pending investigation After the 1 YES 2 NO В 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A ED 6 Could not be 4 Homicide 50 ᇤ COMPL 1 CERTIFYING PNYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner ee stated. TO THE HOSPITAL OF THE FUNERAL D be filed within 72 ho 2 MEDICAL EXAMINER: On th ition and/or investigation, in my opinion, death occured at the time, date and piece, and due to the cause(a) end manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Ybar) BE O.C.M.E. FEB 23 1995 2 SE DF DEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 32. REGISTRAR'S SIGNATURE

TO HE WILL

DIVISION OF VITAL RECORDS, P.O. BOX 68760

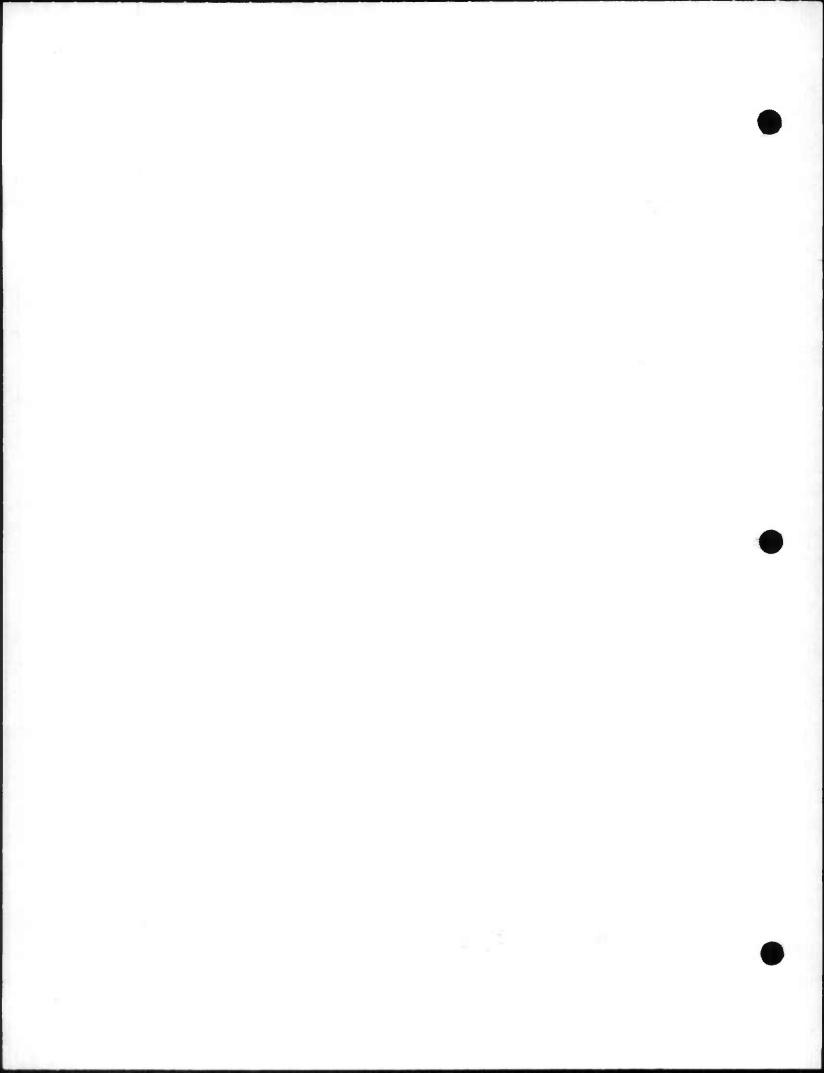
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY

	1. DECEDENT'S NAME (First	Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	James How	ard PL	ANK							Feb. 22	199	YEAR	8,00 An
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs	s. lest birthday)	IF UNDE	R 1 YEAR	IF UNDE	9 24 HRS.	7. DATE OF BIRTH	1))	8. BIRTHP	LACE (State or Foreign
	215-14-153	9	1 🔯 M 2 🗌 F	71	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) Dec. 27 1	023	D(ann	sylvania
	90. FACILITY NAME (If not in		treet end number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE			INTY OF DE	_/
E E	11926 Trog	uois A	venue				Smit	hsbu	ro		Į,	lashin	oton
DIRECTOR	11926 Iroq								- 6			- CONTEN	.60011
I H	100. STATE	10b. COUNT				TY, TOWN							10d. INSIDE CITY LIMITS?
	Maryland	W	ashingto	n	5	mith							LIMITS?
FUNERAL							10	. ZIP COD					IAT COUNTRY?
N	11926 Iroq	uols A				-		217				U.S.A	
	1 Never Married 2 💟	Married	12. WAS DECEDEN FORCES? 1	YES 2	NO NO		If yes, sp	ecify Cubi	m, Mexica	IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No—	14. RACE - Black,	- American Indian, White, atc.
BY	3 Widowed 4 Divo		IF YES, GIVE Y	WW II			1 TYES	2 💢 NO	Specify	C.		Specify.	
8	15. DEC	EDENT'S EDU	CATION		. DECEDENT'S	USUAL	CCUPATIO	ON		16b, KIND OF BU	SINESS/IN	Whi	re
COMPLETED	Elementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5	+)	(Give kind of life. Do NOT L	work done use retired.)	during mo	st of worki	ng	320000000000000000000000000000000000000			
₽ I	0-8		_		Conduc	tor				Railro	ad		
ő	17. FATHER'S NAME (First, M	iddle, Last)						18. MOT	HER'S NAI	ME (First, Middle, Maiden	Surneme)		
BE (Howard L.	Plank						R	uth	M. Peters			
0	190. INFORMANT'S NAME (7	ype/Print)			19b. MAILIN	G ADDRES	S (Street a	nd Numbe	r or Rural F	oute Number, City or Tow	n, State, Zi	p Code)	
F	Betty M. P				11926	Irc	quoi	s Av	enue	Smithsbu	ırg,	Md. 2	1783
	20a, METHOD OF DISPOSIT	ION	oval from State	20b. PLA	CEANDDATE	OF DISPO	SITION (Na	ime of		OATE 20c. LO	CATION -	City or Town	n, State
	4 Donation 5 Other	(Specify)		Res	cremetory or the Have	n Ce	mete	ry 2	-24-	95 Hage	rsto	wn, M	aryland
	21. SIGNATURE OF FUNERA	-	1,0			22.	NAME A	ND ADDRE	SS OF FAC	Minnich	Fun	eral	Home
	7.	red s	Nesta	1		4	15 E	. Wi	1son	Blvd. Hag	erst	own,	Md. 21740
	23. PART i. Enter the di	seases, or o	complications the	t caused the	death. Do								Approximata
	anock, or h	eart fallure.	List only one ceu	tee on each	iina.								Interval Between Onset and Death
	disease or condition resulting in death)		a. DUE TO	et. h	tie	1.1.		(3 47
	rosulting in openi,		DUE TO	(OR AS A CON	SEQUENCE C	PF):		INNE					J MINULI
Z	Sequentially list conditi		b										
Ĕ	if any, leading to imme	diata	OUE TO	(OR AS A CON	SEQUENCE C	F):							
2	cause. Enter UNDERLY! CAUSE (Disease or inju		C			_							
ΙĔΙ	that initiated events reaulting in death) LAS	т	OUE TO	(OR AS A CON	ISEOUENCE C	if):							
CERTIFICATION	<u> </u>		d										
	PART II. Other aignifice	nt condition	a contributing to	dasth but n	ot reaulting	in the u	nderiyin	g cause (given in I				VERE AUTOPSY FINDINGS
MEDICAL										PERFOR	-	C	MAILABLE PRIOR TO COMPLETION OF CAUSE
MEC													OF OEATH?
ä	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF D	EATH Y	ES 🔲	NO [UNC	ERTAIN	10			
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOCDITAL	26. P	LACE OF OEA								
, SI	1 - YES 2 - 40		HOSPITAL:	ER/Outpatien	t 3 🗆 DOA	4 Nu		• 5 8 A	sidence	8 Other (Specify)			
표	27. MANNER OF DEATH		28a. DATE OF (Month, D		28b. TIN	IE OF JURY	28c. INJ WO	URY AT		28d. OESCRIBE HOW II	VJURY OC	CURED	
B≼		Pending investigation				М		YES 2	NO				
		Could not be	26e. PLACE O building,	etc. (Specify)	t home, 1erm,	street, 1ec	tory, offic	•		261. LOCATION (Street e City or Town, Stelle)	nd Numbe	r or Aural Rou	ute Number,
립										to the cause(s) end men			
COMPLETE	one) 2 MEDI	CAL EXAMINE	R: On the basis of e	xamination end	or investigation	on, in my	opinion, d	eath occur	red at the t	lime, data and place, en	d due 10 1	he ceuee(s) s	and menner es stated.
اسا	29b. SIGNATURE AND TITLE	OF CERTIFIER	0 1	=				29c. LICE	NSE NUM	BER	29d. DAT	E SIGNED (A	Month, Day, Year)
0 8	Muchael	9.	molon	mel				0	416	(67)		2/27	2/45
=	30. NAME AND ADDRESS OF	PERSON WH	COMPLETED CAUS	SE OF DEATH (ITEM 27) (Type	, Print)					-	1	
	Michael	J. 1	Mc Corma		799	Ho.	rell	Ro	1	Buch	va,	m.	21740
	FEB 2 3 199	Mar)	32. REGISTRA	R'S SIGNATUR	E								
		J HU	An allutions	Markell	a								



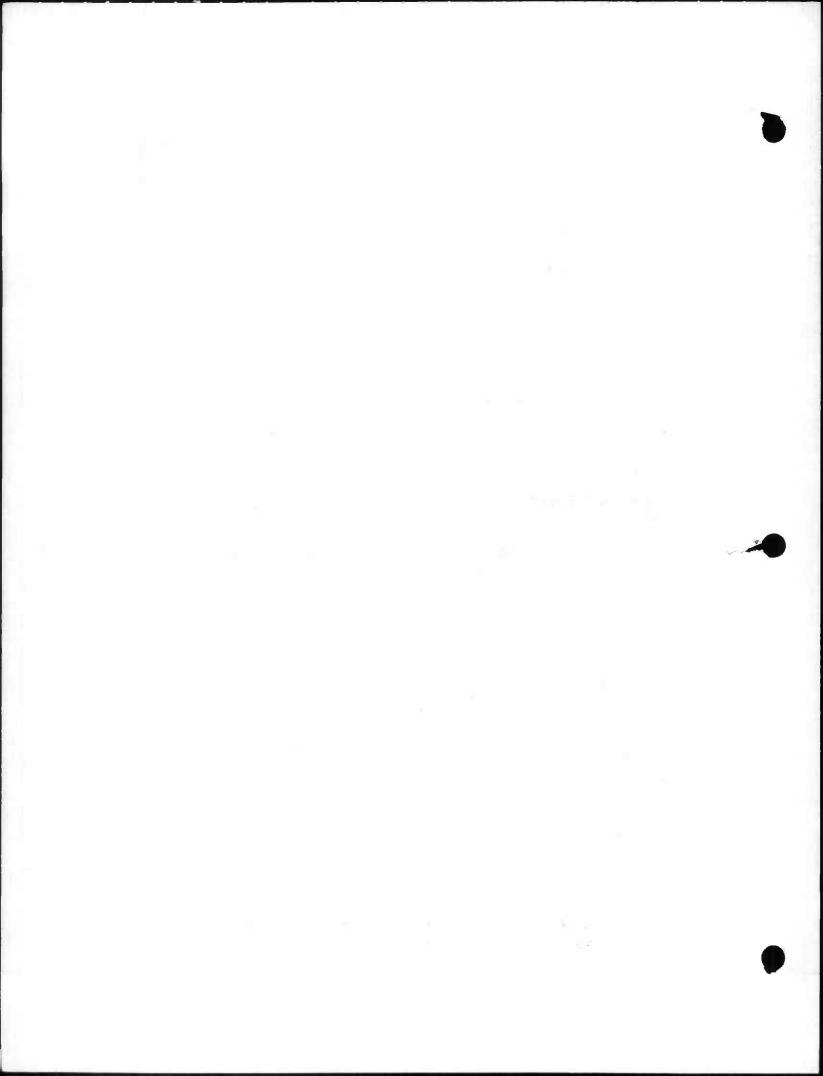
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a neuron state death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. 8

	FOR STATE REGISTRAR		STATE OF I			RTMENT ICATE				MENTAL	HYGIEN	_		
		lorenc		Pritche						MONTH			YEAR 195	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 218-20-8691	L	5. SEX 1 M 2 XX	6. AGE (In yrs. 81	YRS.	IF UNDER 1	DAYS	IF UNDER HOURS	MIN.	Oct	Dey, Year)		Country	laryland
TOR	9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Cambridge						ATH		7.0	orche				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Dorchester Cambridge										10d. INSIDE CITY LIMITS? XX YES 2 NO			
FUNERAL	100. STREET AND NUMBER 1417 Stone	Bound	lary Road				101.	ZIP CODE 2161				1	IZEN OF W	VHAT COUNTRY?
To No Specify: White							t, White, etc.							
COMPLETED	15. DECE (Specify only Elementary/Secondary (0-1		CATION completed) College (1-4 or 5	+)	(Give kind of Me. Do NOT i	work done of the retired.)	uring mos	t of worldn	g	16b.	Mail			or
BE CON	17. FATHER'S NAME (First, Mid Olney Per	ry F	Ross, Sr.							ME (First, M	liddle, Maiden Vers	Surname)		
70	W. Clifton	Prito	hett		5702	Beach	n Ha	ven				larke	t, M	d. 21631
	20a. METHOD OF DISPOSITION OF DISPOS	3 🗆 Rem Specify)		20b. PLAC cornetery, o DOT C	e AND DATE rematory or e neste	of disposition of their place) er Men	nori	al P		3/1		cation - oridg		
	22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Maryland 21613							and 21613						
	23. PARTA. Enter the dis shock, or he IMMEDIATE CAUSE (Fine disease or condition resulting in death)	art fallure,	List only one cau	Sasti	ne.	not enter t	the mod	le of dyi	ng, sucl	n as card				Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injurithat initiated events resulting in death) LAST	late IG y	C	(OR AS A CONS			_							
PHYSICIAN: MEDICAL C	PART II. Other significan	st condition	es contributing to	death but not	t resulting		derlying	cause g	given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAI	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	MEDICAL	HOSPITAL:	☐ ER/Outpatient	3 DOA	OTHER	:			6 C Other				
ву Рну	27. MANNER OF OEATH 1 Netural 5 P 2 Accident In	ending	28a. DATE Of (Month, D		28b. TR		28c. INJU WOF 1 Y	RY AT		_	CRIBE HOW I	NJURY OC	CURED	
8	3 Suicide 6 C	ould not be etermined	28s. PLACE C building,	of INJURY — At atc. (Specify)	home, farm,	street, facto	ery, office			28f. LOCA City o	TION (Street to Town, State)	and Number	or Rurel R	loute Number,
COMPLET			CIAN: To the best of) and manner as stated.
BE	296. SIGNATURE AND TITLE O	Mrs	~~					29c. LICE	S9	1BER 749		29d. DAT	2/	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEATH (IT	Out	Print)	~>	Len	~	Ece	ston	m.	5 5	2160/
	31. DATE FILED (Month, Day, YEE	1995		uns signature under Koz	Hall									



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zer hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020**

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: It item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND	MENTAL	REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)		- CLITTI	IOAIL O	DEATH	2. DATE	OF OEATH		3. TIME OF DEATH
PEARL R. PRUE					MONTH	d DAY		YEAR .
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	FEB.	21 OF BIRTH	199	5 16:40 A M BIRTHPLACE (State or Foreign
009-28-5770	1 □ M 2 💢 F 92	YRS.	MONTHS DAY	8 HOURS MIN.		. Day, Year) -1903		Country)
9e. FACILITY NAME (If not institution, give st	reet end number)		9b. CITY, TOW	N OR LOCATION OF C		1703		Y OF DEATH
SALISBURY NURSING	& Rehab Cent	er	SALTS	BURY, MD.				MICO
RESIDENCE OF DECEDENT								
	_		Y, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?
De. Susse	X	Lau	rel	10f. ZIP CODE				1 TYES 2 X NO
Rt#4 Box 892				19956			USA	N OF WHAT COUNTRY?
11, MARITAL STATUS	12. WAS DECEDENT EVER IN	I II S. ARMED	12 WAS	DECENDENT OF HISPA	MIC OBIGIN	2 (Casally, Van a		
1 Never Merried 2 Merried	FORCES? 1 YES	2 X NO	If yes	specify Cuben, Mexic	en, Puerto F	r (Specify tes o Rican, etc.)	# NO- 14	Black, White, etc.
3 XWidowed 4 Divorced		1123		res 2 XNO Spec	ny:			Specify: White
15. DECEDENT'S EDUC (Specify only highest grade		18e. DECEDENT'S	USUAL OCCUP	ATION most of working	18b.	KIND OF BUSIN	NESS/INDUS	
Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)	The state of the s		77 - 14	-1	
12		Cook				Hospit	_	
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N			ımame)	
Nathan H. Barry		1				Barry		
THE COLUMN TWO IS NOT THE COLUMN				et end Number or Rural Laurel,			State, Zip Co	ode)
Sheridan W. Prue		PLACE AND DATE			DATE		7.01	
20e. METHOD OF DISPOSITION 1 Burlel 2 CCremetion 3 Remo	wal from State cem	etery, crematory or or ISTERN Sh	ther piece)	ematorv	2-2			y or Town, State
21. SIGNATURE OF FUNERAL SERVICE LIC		DCCIII DI	22. NAME	AND ADDRESS OF F	ACILITY	7	- 8	
Don'the ne	1011			t Funeral				
23. PART I. Enter the diseases, Dr c	STATE OF THE PARTY	I the death Do		W. St. La				
shock, or heart fellure. I IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	DUE TO (OR AS A	ach ilne.				,		interval Between
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
PART II. Other algolficant conditions	contributing to death be	ut not resulting i	In the underly	ring cause given in	n Part i.	24a. WAS AN AI		24b. WERE AUTOPSY FINDINGS
cellmo						PERFORM 1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
					_	1 123 2 [P NO	OF DEATH?
DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DEATH YE	S 🗆 NO	UNCERTA	IN 🗆			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT		ne)				
1 YES 2 AND	HOSPITAL: 1 Inpetient 2 ER/Oulp	etlent 3 DOA	OTHER:	lome 5 🗆 Residence	8 🗆 Other	(Specify)		
27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c.	INJURY AT WORK?	28d. DE\$	CRIBE HOW INJ	URY OCCU	RED
1 Action 5 Pending 2 Accident Investigation			4.0	YES 2 NO				
3 Suicide 4 Homicide Suicide 5 Could not be determined See PLACE OF INJURY — At home, ferm, streel, fectory, office building, etc. (Specify) See PLACE OF INJURY — At home, ferm, streel, fectory, office City or Town, Stete)								
290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowl	edge, death occurre	ed at the time, o	lete end place, end du	e to the ceu	se(s) end menne	er es stated.	
								euse(s) end menner es stated.
29b. SIGNATURE AND TITLE OF CERTUPIER				29c. LICENSE NU	IMBER	T	29d. DATE S	IGNED (Month, Day, Yeer)
0//14/6/-				D-29349)		> 3	22/8
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	Print)				-	1
WILLIAM ROBINS, M	LD. 1104 HEA	LTHWAY F	DR SA	LISBURY,	MD- 2	21801		
FEB 23 1995	JULY OF MUCH							

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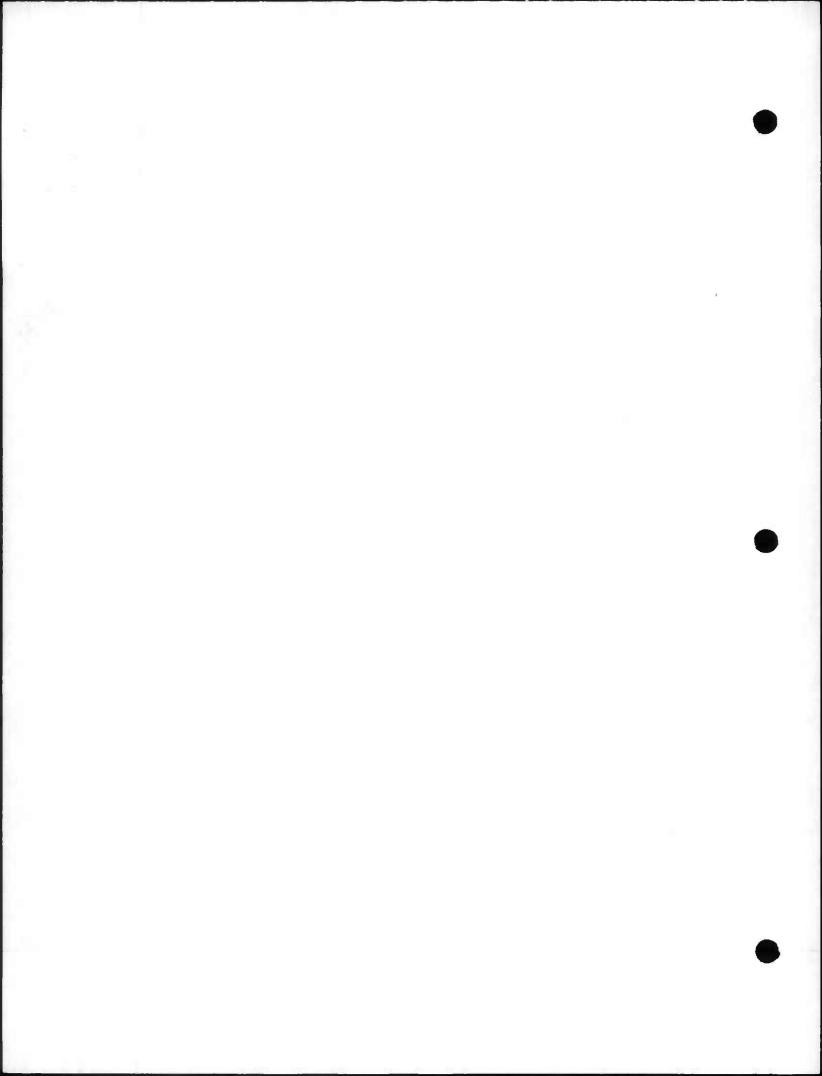
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burial-transit permit. Pages 1, 2, 3 should the SE use ò detached once. 9 TO should notified page 9 must director, examiner funeral in by the medical 6 filled cremation, traumatic event, the completely burial. and or nor to other t attending phys 5 Mental Injury, and and shows any signed l peen Dept. 23 Hem State certificate 6 the marked, with (death After 60 DIRECTOR: after item 28 hours TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 ho

						95	07945	
FOR STATE REGISTRAR	STATE OF	MARYLAND / DEPAR CERTIF	RTMENT OF H		MENTAL HYGIENI REG. NO.	E		
1. DECEDENT'S NAME (First ONEIT		RKER			2. DATE OF DEATH MONTH DA	1995	3. TIME OF DEATH	M
4. SOCIAL SECURITY NUME 2/316-8		6. AGE (In yrs. lest birthday) 7/ YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JUNE 25,	Cor	RTHPLACE (State or Foreign unity) NARY LAND	-
90. FACILITY NAME (If not in	nstitution, give street and number)		9b. CITY, TOWN C	OR LOCATION OF D	EATH	9c. COUNTY OF		_
707 DEC		75-	BER	LIN		WOR	CESTER	
RESIDENCE OF DEC								
10e. STATE	10b. COUNTY		Y, TOWN OR LOCAT	TION			10d. INSIDE CITY	
MARYLAND	WORCEST	ER	BERL	IN			LIMITS?	
10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?	_
= -		1 0	i .	0 0			_	

2/3-16 90. FACILITY NAME DIRECTOR 707 RESIDENCE C 10e. STATE MARYLA 10e. STREET AND I FUNERAL 707 DECATUR APTS 21811 STATES LENITED 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) ELEM ENTARY LABORER DOMESTIC 17. FATHER'S NAME (First, Middle, Cast) 18. MOTHER'S NAME (First, Middle, ALFOUNZIA BE 19e. INFORMANT'S NAME (Type/Print) 9 Gloria 21811 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 1 Description | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | Disposition | itory or other place) 2/25/9 21. SIGNATURE DE TUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
LEWIS N. WESSON MD 21801 Rd. Salisbury 23. PART I. Enter the diseases, or complications that caused the death. Do not enter Approximata shock, or haart failura. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition___ Me resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? ; MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 100 OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: Ser/Outpatient 3 DOA 1 VES 2 NO **EXAMINER?** OTHER: 4 - Nursing Home 5 - Residence 8 - Other (Specify) 28e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b, TIME OF 28d, DESCRIBE HOW INJURY OCCURED Natural 2 Accident 5 Pending investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town. State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and me (Check only one) 2 MEDICAL EXAMINER: On the ba 296. SIGNATURE AND PUBLE OF CERTIFIER 29c. NCENSE NUMBER BE 069 9 ETEO CAUSE OF OEATH (ITEM 27) (Type, Print) 560 Riverside rawshan

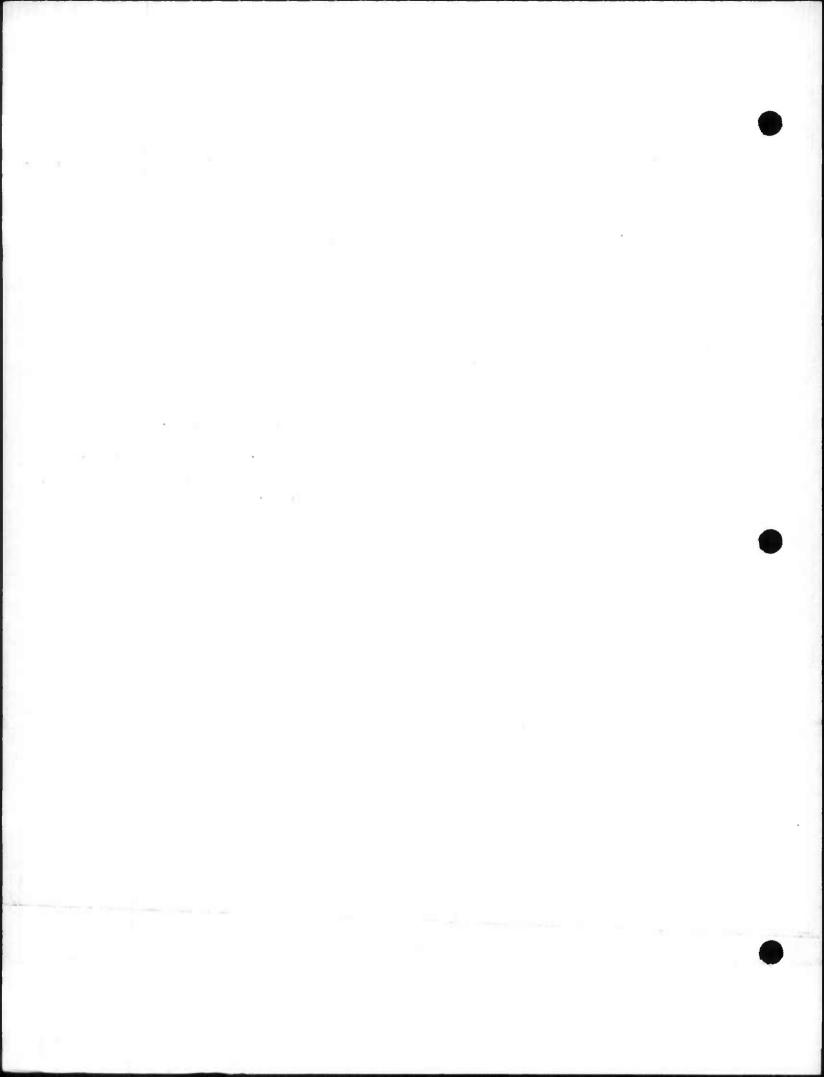
32. MEGISTRAN'S SIGNATURES



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zer frours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
IMPORTANT. It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)	DELLA RUTH				2. DATE OF DEATH	7575	3. TIME OF DEATH 5; 30 p M		
	213-16-8883	□ m 2 ∅ F 84	YRS. MO	NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4 3 12	6. BIRT	HPLACE (State or Foreign DLETREE, MD.		
TOR	9a. FACILITY NAME (If not institution, give street 425 COVIN	NGTON STREE		SNOW!	ILL	АТН	WORCE			
DIRECTOR	MD . WORD	CESTER	2.5	OWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 V YES 2 NO		
FUNERAL		OVINGTON ST		- 2	21863		10g. CITIZEN OF			
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, spec	IDENT OF HISPAN Ify Cuban, Maxical NO Specify	IC ORIGIN? (Specify Yea n, Puerto Ricen, etc.)	Blac	E — American Indian, k, White, atc. ify: BLACK		
COMPLETED	15. DECEDENT'S EDUCATII (Specify only highest grade com Elementary/Secondary (0-12) * 8th	ON pleted) oilege (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use re DOMEST)	done during most tired.)	of working	166, KIND OF BUS	KEEPER			
BE COM	17. FATHER'S NAME (First, Middle, Leat) GEORGE FIN	INEY				ME (First, Middle, Maiden : MARY CLA	Sumame) YTON			
7	19a. INFORMANT'S NAME (Type/Print) EMMA BLAKE		131 (SUNBY ST	TREET: S	NOWHILL, M	ID. 21863			
	20a. METHOD OF DISPOSITION 1 XBurial 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	from State	JUL SPRING	GOOD CHL	JRCH CEM	DATE 20c. LOC 1.2-18 GIR	DLETREE,	MD.		
	21. SIGNATURE OF FUNERAL SERVICE LICENS SOUTH B.	Golley	/	SALISBU	JRY, MD.			RSEY ROAD,		
	23. PART I. Enter the diseases, or com- shock, or heart failure. Liet IMMEDIATE CAUSE (Finel disease or condition resulting in death)	CACHERI	ch lina.	AWITI	on			Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL CE	PERFORMEO? 1 YES 2 NO OF							D. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO		
ICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	O		ES NO	(62)				
BY PHYS	1 VES 2 NO 10 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	29a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	F 28c. INJUI	TA YE	6 Other (Specify) 28d. OESCRIBE HOW IN	JURY OCCURED			
	3 Suicide S Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Special	At home, farm, stree	et, factory, office		261. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN One) 2 MEDICAL EXAMINER: O							s) and menner as stated.		
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER / RObe of C. Land 10 30. NAME AND ADDRESS OF PERSON WHO CO		P Mas, M	0	D05865	IBER	29d. DATE SIGNED	(Month, Day, Year)		
	104 N. Bay Stre	eet, Snow	Ні11. м		3					
	31. DATE FILED (Month, Day, Year) FEB 2/ 1995	Jalia d'avels	or Rardell							



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DIRECTOR: After

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24
NO NO	SNIDING
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) CONRAD F. PERSOLIO 2. DATE OF DEATH 3. TIME OF DEATH orred es solio 10: 25 A 2 95 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MARCH 29, 1931 DAYS. HOURS 1 X M 2 - F WILMINGTON, DEL. 221-26-6977 YRS. 63 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY DELAWARE SUSSEX SELBYVILLE 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? RT # 2 BOX 185 GUMBORO ROAD 19975 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian Black, White, atc. 1 Never Married 2 Married FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 XNO Specify 1 TYES 2 NO BY Specify: 3 Widowed 4 Divorced 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. OECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest gi (Give kind of work done life. Do NOT use retired.) Щ Elementary/Secondary (0-12) College (1-4 or 5+) CLERK & SCHOOL TEACHER EDUCATIONAL COMPL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCIS A. PERSOLIO DOROTHEA COOK Ħ notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 NANCY LONG PERSOLIO GUMBORO ROAD RT # 2 BOX 185, SELBYVILLE DE 19975 20a. METHOD OF DISPOSITION pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must 2 Cremation 3 lon 5 Other (Specify) CAPE HENLOPEN CREMATORY 2/11/95 FRANKFORD, DELAWARE 4 Donation traumatic event, the medical examiner HERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MELSON FUNERAL SERVICES Melion FRANKFORD, DELAWARE 19945 23. PART I. Enter the dhasses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition_ obstructive pulmoning ChroNIC resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF) Mental Hygiene that initiated events resulting in death) LAST Injury, c signed by the a PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY MEDICAL shows any 1 TES 2 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one. OTHER: 1 VES 2 NO 1 Inputient 2 ER/Outputient 3 I DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) the 0 27. MANNER OF DEATH 28s. DATE OF INJURY this c 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, INJURY 1 X Natural М 1 YES 2 NO BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide TO THE HOSPITAL, OR ATT TO THE FUNERAL DIRECTY DE filed within 72 hours at IMPORTANT; If item 2 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated 29b. SIGNAPURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2/11 9 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Berlin mD 2181 9733 Herith 32. ACGISTRATES SIGNATURE P 31. DATE FILED (MONTH DAY, YEAR) 1995 DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

GUMBORO ROAD RT # 2 BOX 185, SELEYVILLE DE 19975

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NIT 24 hours after death. Page 6 may be retained by the hospit	funeral director, page 5 :	
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95 07948 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Passano February WILLIAM ROBERT 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS HOURS 218-22-4183 1 🔀 M 2 🗌 F 67 YRS January 11, Maryland 9a. FACILITY NAME (If not institution, give 96. CITY, TOWN OR LOCATION OF DEATH SALISBURY 9c. COUNTY OF OEATH PENINSULA REGIONAL MEDICAL CENTER WICOMICO DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Wicomico Quantico YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21856 USA Main St. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married BY Specify: 3 Widowed 4 Divorced Army White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5 +) 14 Civil Engineer Steel Fabricator 17. FATHER'S NAME (First, Middle, Last) 16, MOTHER'S NAME (First, Middle, Maiden Surname) BE Joseph Sewell Passano Sarah R. Weaver 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Reda M. Passano 21856 P.O. Box 13, Quantico, MD 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Salisbury Crematory Salisbury, MD 21801 RAL SERVICE LICE 22, NAME AND ADDRESS OF FACILITY Holloway Funeral Home 24 501 Snow Hill Rd., Salisbury, MD 21801 23. ARY I. Enter the diseases, or complications that caused the death. Do not sntar the mode of dying, such as cardisc or respiratory arrest, Approximate shock, or heart failure. List only one gaus intarval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) 15 DUE TO (OR AS A CONSEQUENCE OF) DUE TO (DR AS A CONSEQUENCE OF CERTIFICATION Sequentisity list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury e. DUBJO IOR AS A CONSEQUENCE that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 24s. WAS AN AUTOPSY PHYSICIAN: MEDICAL

DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH		NO UNCERTAIN	_ 10	PERFORMED? YES 2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 HO	
25. WAS CASE REFERRED TO MEDICAL	26. PLACE (OF DEATH (Check	only one)				
EXAMINER?	HOSPITAL:	DOA 4 Nur	R: sing Home 5 - Residence	6 Other (Spec	tfy)		
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE	HOW INJURY OCCUP	RED	
3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, term, etreet, factory, office building, etc. (Specify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of my knowledge, death	occurred at the t	ime, data and place, and due	to the cause(a) e	and manner ea stated.		

end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D 20441 2-16-95

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RAFFetto Joseph FEB 21 1995

32 REGISTRAR'S SIGNATURS

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the attending physician and completely: Mental Hygiene prior to burial, crematic

this certificate has been signed by with the State Dept. of Health and

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31. DATE FILED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	PHYSICIAN:
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH DAY YEAR FEB. EMOGENE B. PHILLIPS 15 1995 11:19 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 M 2 F 213-22-8687 SEPT. 67 16,1927 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 12242 SHEPPARDS CROSSING ROAD RESIDENCE OF DECEDENT WHALEYVILLE WORCESTER 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND WORCESTER WHALEYVILLE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12242 SHEPPARDS CROSSING ROAD 21872 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 TNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2X NO Specify: ВҰ 3 Widowed 4 Divorced WHITE WHITE 16a. DECEDENT'S USUAL OCCUPATION

work done during most of working ETED. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 11 HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) To LLOYD BRITTINGHAM BE ELSIE LEWIS notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DEBORAH E. DAVIS 8013 SHOCKLEY ROAD, SNOW HILL, MARYLAND 21863 pe 20s. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Buriel 2 Cremation 3 Removal from State must DALE CEMETERY 2/18/95WHALEYVILLE, MARYLAND 21. SIGNATURE OF PUMERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY HASTINGS FUNERAL HOME, SELBYVILLE, DE Hase W medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death event, the disease or condition DUE TO (OR AS A CONSEQUENCE OF): OCCLUSION resulting in death) MEDIATE ASC V D
DUE TO (OR AS A CONSEQUENCE OF): traumatic NO EVERAL YR: Sequantially list conditions, If any, laading to immediate cause. Enter UNDERLYING CERTIFICAT CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL amy 1 TYES 2 1 NO OF DEATN? Shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 YES 2 NO OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 0 26s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN 26c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending Investigation 1 YES 2 NO BY DIRECTOR: After the hours after death item 28 is man 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide 29s. CERTIFIER

1 CERTIFYING PHYSICIAN: To this best of my knowledge, death occurred at this time, data and place, and due to the cause(s) and manner as stated. 2/ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITATO THE FUNERA
TO THE FUNERA
De filed within 7.
IMPORTANT: 1 TITLE OF CERTIFIER 29b. SIGNATURE AND 29d. DATE SIGNED (Month, Day, Year) 29c LICENSE NUMBER BE

203 SNOW ST.

WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32. ABGISTRAP'S SIGNATURE Pardall

· HOLZWOLTH

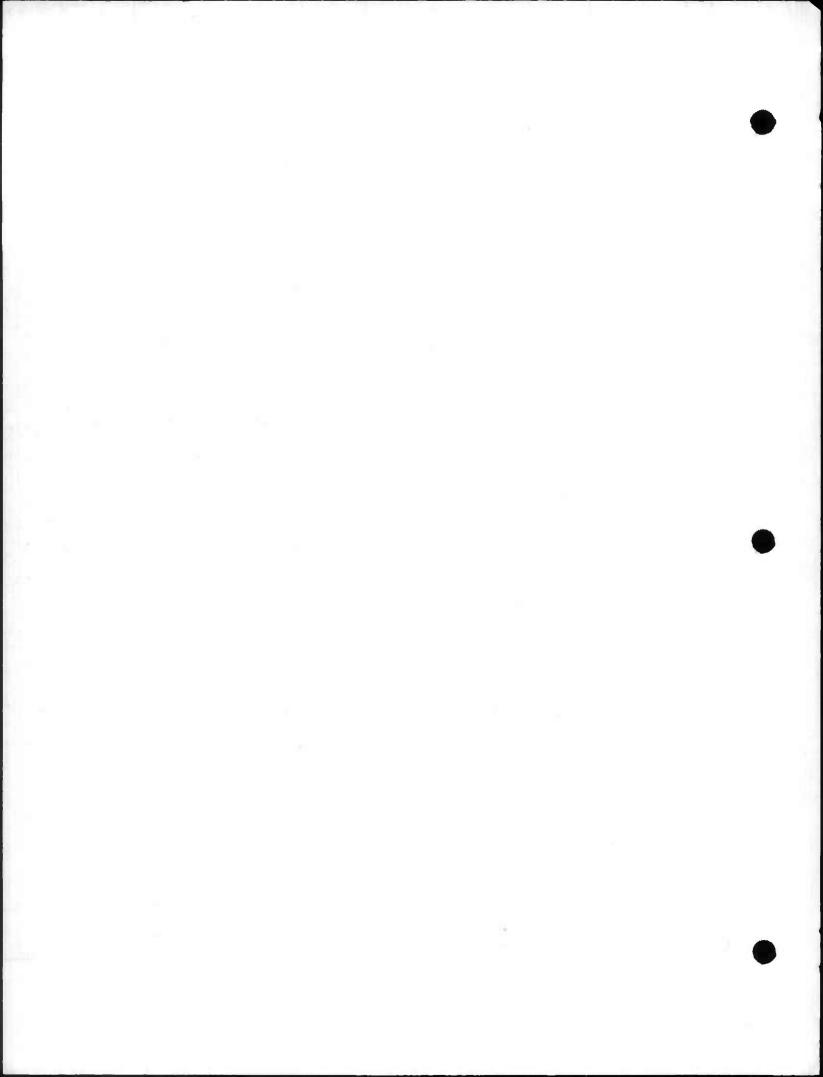
1995

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SNOW HILL, Mo.

2-16-95

21863



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIFIC	CATE O	F DEATH	RE	G. NO.		
t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OR	ATH		3. TIME OF DEATN
William ¹	A .		Pric	e	Feb.	16 1°	995	10:06 a M
4. SOCIAL SECURITY NUMBER	1		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIE	RTH	8. BIRT	NPLACE (State or Foreign
213-16-5846	1 M 2 D F	81 YRS.	ONTHS DAYS	HOURS MIN.	Aug.	24,191	L3 Coun	Md.
9a. FACILITY NAME (If not institution, give a	treet and number)	1	96. CITY, TOWN	OR LOCATION OF D			UNTY OF I	DEATH
EASTON MEMOR	TAT. HOSPT	тат.	FΔ	STON		7	TALB	ОТ
RESIDENCE OF DECEDENT	TAD HODII	IND	LIN	BION				<u> </u>
toe, STATE tob. COUNT	Y	t0c. CITY,	TOWN OR LOC	ATION				tod. INSIDE CITY LIMITS?
MD	TALBOT		EA	STON				TY YES 2 NO
10e. STREET AND NUMBER				Of, ZIP CODE		tog. Cr	TIZEN OF	WHAT COUNTRY?
507 GLENWOOD	AVE,			2160	1		USA	
ti, MARITAL STATUS	t2. WAS DECEDENT EVER FORCES? t YES	IN U.9-ARMED		ECENDENT OF HISPAI			14. RAC	CE — American Indien, ck, White, etc.
t Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR			specity Cuban, Maxica ES 2 □XNO Specif		ntc.)	Sper	City:
	<u> </u>							BLACK
t5. DECEDENT'S EDU (Specify only highest grade	CATION completed)	tea. DECEDENT'S US (Give kind of wor	rk done during i	TION most of working	16b. KIND	OF BUSINESS/IN	IDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use :	retired.)					
0.8		CHUAFF	ER		P	RIVATI	E FA	MILY
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle,	Maiden Surname)		
WILLIAM WI	LSON PRICE			AN				
t9a. INFORMANT'S NAME (Type/Print)				t and Number or Rural				
LEONARD T. JO	OHNSON	320 E	AST A	VE. EAS	TON, MD	.21601	L	
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ram		b. PLACE AND DATE OF			OATE	20c. LOCATION -		
4 Dopation 9 Other (Specify)	R	TCHARDS	MEM.	PRK. 2/	22/95	EAST	M,NC	D
SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	7	22. NAME	AND AGORESS OF FA	CILITY CED	VICE		
11	1 1	U					T MD	21601
23. PART I. Enter the diseasea, or	complications that cause	d the death. Do not		E. DOVE				
ahock, or heart fallure.	List only one cause on	each line.	A	loud or dying, auc	n aa cardiac o	r reapiretory a	rreat,	Approximata Interval Batween
IMMEDIATE CAUSE (Final disease or condition	1. m		de	700	11-0	2 0		Onset and Daath
resulting in death)	/ COVOV	an	>1.1	27	MSE	ivel		years
	OUE TO (OR AS	A CONSEQUENCE OF:		/				1
Sequentially list conditiona,	b. DUE TO OR AS	A CONSEQUENCE OF):		L.				V
If any, leading to immediate cause. Enter UNDERLYING	DOE 10 (ON AS	A CONSEQUENCE OF):						
CAUSE (Disease or Injury	C. DUF TO (OR AS	A CONSEQUENCE OF):						
that initiated events resulting in death) LAST	202 10 (011 NO	A CONSCIONATION OF J.						İ
	d							
PART II. Other aignificant condition	a contributing to death	but not reaulting in	the underlyl	ng cause given in		MAS AN AUTOPSY	241	b. WERE AUTOPSY FINDINGS
						ERFORMED?	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					' ' '	YES 2 NO		OF DEATN?
DID TOBACCO USE CONT	PIRLITE TO CALISE (DE DEATH VEC	BCNO I	T LINICEDTAIL				1 TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL	MIDOTE TO CAUSE C	26. PLACE OF DEATN			<u>ч Ц Т</u>			
EXAMINER?	HOSPITAL:	24.74	THER:					
27, MANNER QE-DEATN	1 ☐ Inpatient 2 ☑ ER/Out 28e. DATE OF INJURY	28b. TIME 0		JURY AT		**		
1 Natural 5 Pending	(Month, Day, Year)	INJUR	IY W	ORK?	200. DEŞCHIBE	NOW INJURY OF	CURED	
2 Accident Investigation	20- DI ACE OF IN HID	Y 44 h		YES 2 NO				
3 Suicide 8 Could not be 4 Nomicide determined	building, etc. (Spe	Y — At home, term, stre	eet, factory, off	Ice	28t, LOCATION City or Town	(Street and Number, State)	er or Rural	Route Number,
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	CIAN: To the best of my know							
one) 2 MEDICAL EXAMINE	R: On the beals of examination	on and/or investigation,	In my opinion,	death occured at the	time, data and pl	eca, and dua to t	the cause(a) and manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUM	ABER	29d. DA	TE SIGNE	O (Month, Day, Year)
1/hr) A	NO				2-	
30. NAME AND ADDRESS OF PERSON WN	O COMPLETEO CAUSE OF	EATN (VIEM 27) (Type, Pr	rint)	D1531	2			/3
-	6.			П	261	01665		
Thomas Fauntle 31. DATE FILED (Month, Day, Year)	.32. REGISTRAR'S SIGN		Court	Easton	Md.	21601		
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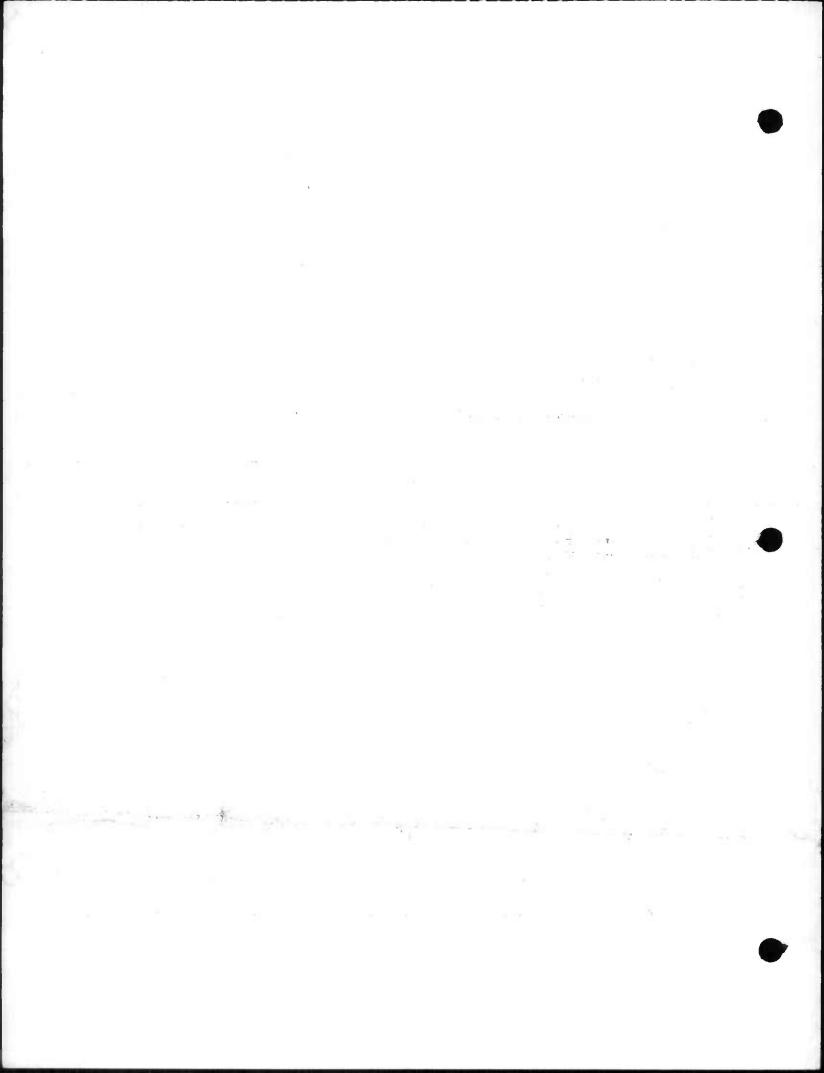
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG	NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Andrew	Polloc	k			2. DATE OF DEATH MONTH Feb.		1995	3. TIME OF DEATH 9:35 P M	
TOR	4. SOCIAL SECURITY NUMBER 232-22-7408		(In yrs. last birthday)	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye NOV . 12	44	8. BIRTH	IPLACE (State or Foreign	
	Se. FACILITY NAME (If not institution, give street end number) 1111 University Blvd., West, #1414 Silver Spring Montgomer RESIDENCE OF DECEDENT							HTAB		
DIRECTOR	10e. STATE 10b. COUNT	tgomery Silver Spring						10d. INSIDE CITY LIMITS? 1 YES 2 NO		
BY FUNERAL	1111 University Blvd., West, #1414			101.	101. ZIP CODE 20902			10g. CITIZEN OF WHAT COUNTRY? USA		
	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES GIVE WAR OR E	2 NO	If yes, spe	ENDENT OF HISPAN ocity Cuben, Mexica 2 1 NO Specify	NIC ORIGIN? (Special, Puerlo Rican, ato	'y Yes or No-	14. RACE Black Speci	E — American Indian, k, White, etc.	
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16e. DECEDENT'S USI (Give kind of work	UAL OCCUPATIO	N st of working	16b. KIND O	F BUSINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Brick I	tired.)	a co morang	Mas	sonery			
8	17. FATHER'S NAME (First, Middle, Last) John Pollock					ME (First, Middle, M. ia Simko				
H	19e. INFORMANT'S NAME (Type/Print)	_	19h MAILING AD	DBESS (Street or		Poute Number, City of		In Code)	20002	
5	Dorothy Pollock								20902 r Spring,MD	
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremeflon 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campatary, Cremeflory of other place) HOLY Cross Cemetery 2/25 Clarksburg, West									
!	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines—Rinaldi Funeral 11800 New Hampshire Avenue Silver Spring, Maryland 20904									
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximete									
	milarvai Deliv								Onset and Daath	
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL O	PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAL							. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
H H K	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Out	patient 3 DOA 4 (8 Other (Specify, 28d, DESCRIBE H		CHRED		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WOF	RK? ES 2 NO		5 1 1 1 O O	CONED		
- 1	3 Suicide 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						loute Number,			
COMPLETED		CIAN: To the best of my know							end menner ee stated	
H C	29b. SIGNATURE AND TITLE OF CERTIFIER				MBER 29d. DATE SIGNED					
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF THE	Dun Dari			1775 2/2		3/45		
	Fredérick G. Barr,	M.D. 5454	Wisconsin A		345, Che	evy Chas	e, Mar	y1and	20815	
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN								



		<i>F.</i>	FOR 1 - STATE REGISTRAR		MRT ND / DEPART CERTIFIC	MENT OF I	HEALTH AND ME	NTAL HYGIEN	9 5 1 4 n	Ty	7952
			DECEDENT'S NAME (First, Middle, Last)		do Palma			DATE OF DEATH DON'TH	WY 75 10	YEAR	TIME OF DEATH
			4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR		DATE OF BIRTH			9:30 A MCE (State or Foreign
	D		578-74-3155	1 ⋈ M 2 □ F 4	6 YRS.	ONTHS DAYS		month, Day, Year)	1040	Guate	-
	3 should	_	9e. FACILITY NAME (If not institution, give		9	b. CITY, TOWN	OR LOCATION OF DEATH			Y OF DEAT	Н
	۲۵	ECTOR	4710 Bartram St	reet		Rockv	ille		Montgomery		
	Pages 1,	EC	10e. STATE 10b. COUNT	ry	10c. CITY,	TOWN OR LOCA	TION			10-	d. INSIDE CITY
	=	DIR		tgomery	R	ockvil	le			1 (LIMITS?
	t permit.	RAL	10e. STREET AND NUMBER			10	H. ZIP CODE		10g. CITIZE	N OF WHA	T COUNTRY?
	transi	FUNER	4710 Bartram St:	12. WAS DECEDENT EVER IN I	10 401100		20853			<u>temal</u>	
020	physician burial-trar		1 Never Married 2 X Merried	FORCES? 1 YES	2 NO	If yes, sp	CENDENT OF HISPANIC Of Decify Cuben, Mexican, Pu	RIGIN? (Specify Ye erto Rican, etc.)	s or No— 1	Black, W	American Indian, hita, etc.
2-0	attending physician. se as the burial-transit	ВУ	3 Widowed 4 Divorced	W TES, GIVE HAR OR DAI	E3		s 2 □ NO Specify: Jatemalan		1	Specify: White	
	n aft	ETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S US (Give kind of wor	rk done during me	ON ost of working	16b. KIND OF BU	SINESS/INDU	STRY	
MORE, MARYLAND age 6 may be retained by the hospita director, page 5 should be detached it	2 S	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT use i			0-			
	detache	COMPL	17. FATHER'S NAME (First, Middle, Last)		Assistan	t Manac	18. MOTHER'S NAME (F	Service		any	
	# E	ш	Santos Palma				Maria A	Per Committee	,		
	5 should	TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street	and Number or Rural Route			ode)	
	De 7		Elsa Lucille Pa		Same		2				
	ector, pa		20e. METHOD OF DISPOSITION 1) Burlal 2 Cremetion 3 Rer	noval from State 20b. F	PLACE AND DATE OF lery, crematory or othe te of Ho	DISPOSITION (Al	metery	DATE 200710	CATION - CH	y or Town,	
	direc		4 ☐ Donation 6 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE Ga	te of He	22. NAME A	ND ADDRESS OF FACILITY	v		cing,	Maryland
ALT	e funeral di		· 810.	11 P		Rapp	Funeral Se	rvices.	P. A.		
80	by the moval.		23. PART I. Enter the diseases, or	complications that caused it	the death Do not	933 G	Gist Avenue	, Silver	Sprin	ng, M	
	ed in by the		shock, or heart fellure.	. List only one cause on eac	ch line.	enter the mo	ode of dying, such as	cerolec or reap	iratory arres	π,	Approximate interval Between
	y fill		IMMEDIATE CAUSE (Fine) disease or condition resulting in death)	Arterioscle	art Dis	sease				10 years	
90	omplete I, cremi		resulting in death)	DUE TO (OR AS A C							10 years
68/		N	Sequentially list conditions.	b							
	or to	CATION	If any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF):						
9	a & a	FIC	CAUSE (Disease or injury that initiated events	c. DUE TO (OR AS A C	CONSEQUENCE OF):						
	5 5 5	RTIFI	reaulting in death) LAST	d							
HDS,	and the att the and Menta any injury,	C	PART II. Other significent condition	ne contributing to deeth but	not regulting in	the underlyin	a ceuse given in Part	I. 24a. WAS AN	ALTTOREY	T 245 ME	RE AUTOPSY FINDINGS
OHI	× 20 0	EDICAL		_			g could given in rail	PERFOR	RMED?	AVA	ILABLE PRIOR TO MPLETION DF CAUSE
5	sign Healt	MED						1 TYES 2	XINO		DEATH?
_	20 5		DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIN [ונ			
4	a se E	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	. PLACE OF DEATH	(Check only one)					
>	ertific the Si	IXSI	1 X YES 2 NO	1 Inpetient 2 ER/Oulpet	lent 3 DOA 4	☐ Nursing Hon	10 5 X Reeldence 6 🗆				
5	fter this certifica eath with the St marked, or 10	Y PHY	1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WC	JURY AT 28d. DRK? YES 2 NO	DESCRIBE HOW I	NJURY OCCUI	RED	
	After death death	D BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY -	- At home, ferm, atre			LOCATION (Street	and Number or	Rural Route	Number.
2	after 28	ETEC	4 Homicide detarmined	building, atc. (Specify	77			City or Town, State)			
5 8	Pour Pour	PLE	29e. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my knowled	ige, death occurred	at Ihe Ilme, date	end place, and due to the	cause(e) end mar	nner ea stated.		
-	FUNERAL WITHIN 72 TANT: 11	COMPL		ER: On the basis of examination s							d manner ee stated.
	THE FUNER filed within	ш	296. SIGNATURE AND TITLE OF CERTIFIE	iR C			29c. LICENSE NUMBER		29d. DATE S	IGNED (Mo	nth, Day, Year)
í	一年重	0	Dot	- Soule	J.,	. C	D 08546		Enh		. 05 100

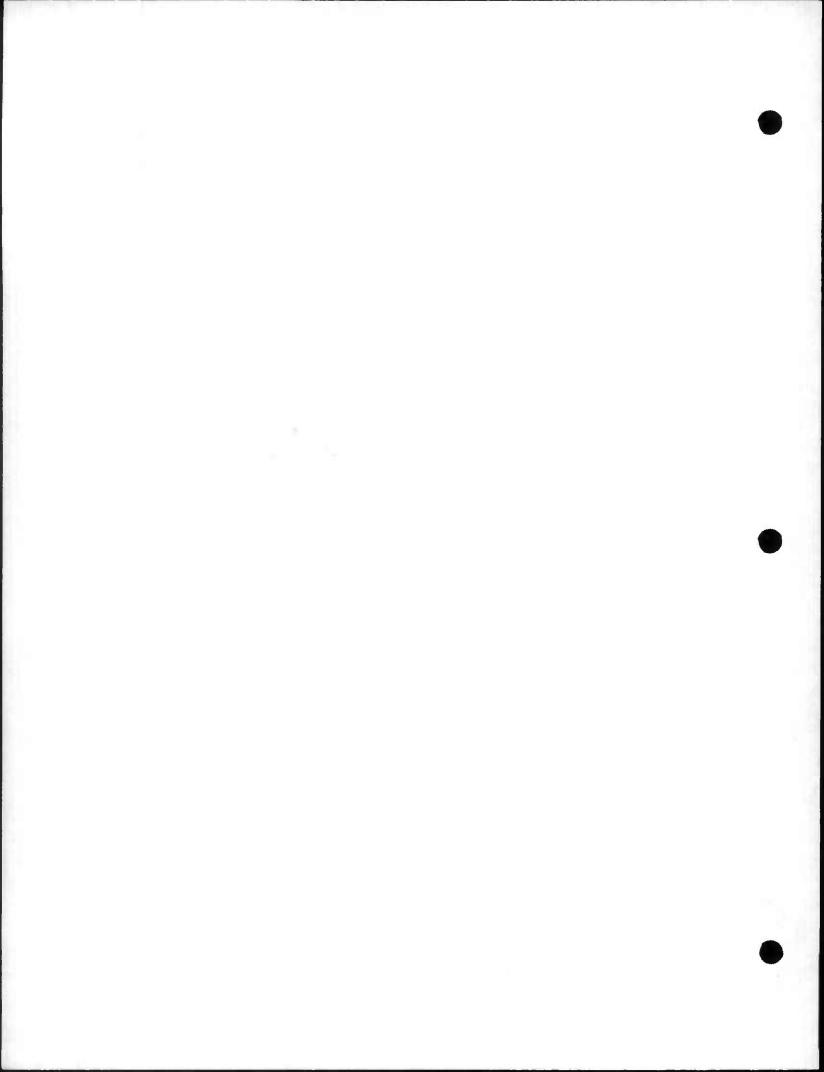
John F. Tauber, M. D., 8218 Wisconsin Avenue, #318, Bethesda, MD 20814

31. DATE FILED (Month, Day, Year)

MAR 02 1995

Julia Davelson Randall

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



O THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	=	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
O THE HOSPITAL DR ATTENDING PHYS	TO THE FUNERAL DIRECTOR: After this of	e filed within 72 hours after death with	MPORTANT: If Item 28 Is marked,

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF				MENTAL HYGIEI					
	1. DECEDENT'S NAME (First, Middle, Lest) DAITON	Plo	CKIE	IOAII		DEATH	2. DATE OF DEATH MONTH DAY FFB 24 95 1/36					
	4. SOCIAL SECURITY NUMBER 577-40-1185	1 📉 M 2 🗌 F	97 vns.	IF UNDER	DAYB	IF UNDER 24 HRS. HOURS MIN.	JUNE 20, 1	397	8. BIRTHPI Country!	EW YORK		
TOR	9a. FACILITY NAME (If not institution, give st CHARLESTOWN RET		UNITY			R LOCATION OF DI VILLE	EATH		ALTIN			
DIRECTOR	10a. STATE 10b. COUNTY	TIMORE			OR LOCATION					IOd. INSIDE CITY LIMITS? YES 2 NO		
FUNERAL	100. STREET AND NUMBER 715 MAIDEN CHOIC	E LANE #321			100	ZIP CODE 1228		1,100		STATES		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? (X) YES IF YES, GIVE WAR OR DA NAVY WW	TES		If yes, spe		NIC ORIGIN? (Specify Year, Puerto Rican, etc.) y:	- American Indian, White, etc. WHITE				
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	Cation completed) Cotlege (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT us NAVAL	work done se retired.)	during mos		166. KIND OF BU		USTRY			
BE COM	17. FATHER'S NAME (First, Middle, List) SOLOMON PLOCKIE 18. MOTHER'S NAME (First, Middle, Melden Surrame) MARY GUNTHER											
70	199. INFORMANT'S NAME (Type/Print) MERLE LEVINE (DAUGHTER) 199. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) P.O. BOX 764 — EAST MARION — NEW YORK 11939											
	20e METHOD OF DISPOSITION 1 IZ Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	AR	PLACE AND DATE				1	LINGTO		IRGINIA		
	21. SIGNATURE OF FUNERAL SERVICE LICE	Lors		DA	NZAN		CLITY DBERG MEMO E PIKE-ROC					
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS/A CONSEQUENCE OF): Approximate interval Between Onset and Death UFA/25											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
_	PART II. Other significant conditions PART II. Other significant conditions	s contributing to death bu	ut not resulting	in the ur	nderlying	cause given in	PERFO	RMED?	3	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDICAL	AORTIC	Stenosis	>				1 TES			OF DEATH?		
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ANO	HOSPITAL:	atlant 3 🗆 DOA	OTHE	R:	ACE OF DEATH (Ch	8 Other (Specify)					
ВУ РНУ	27. MANNER OF DEATH 1 Solution S Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN		28c. INJU WOF	JRY AT	28d. DESCRIBE HOW	INJURY OCC	URED			
	3 Suicide S Could not be 4 Homicide determined	26a, PLACE OF INJURY building, etc. (Speci	RY — At home, farm, street, factory, office				281. LOCATION (Street City or Town, State	and Number	or Flural Roo	ute Number,		
COMPLETED	and a	CIAN: To the best of my knowledge. On the basis of examination								and manner as stated.		
TO BE C	296. SIGNATURE AND STILE OF CENTIFIES	! Non	D	_		29c. LICENSE NUI	MBER 748	29d. DATE ▶ 2	SIGNED (A	Month, Day, Year)		

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

NARRETT
7/1

32. REGISTRAR'S SIGNATURE

15

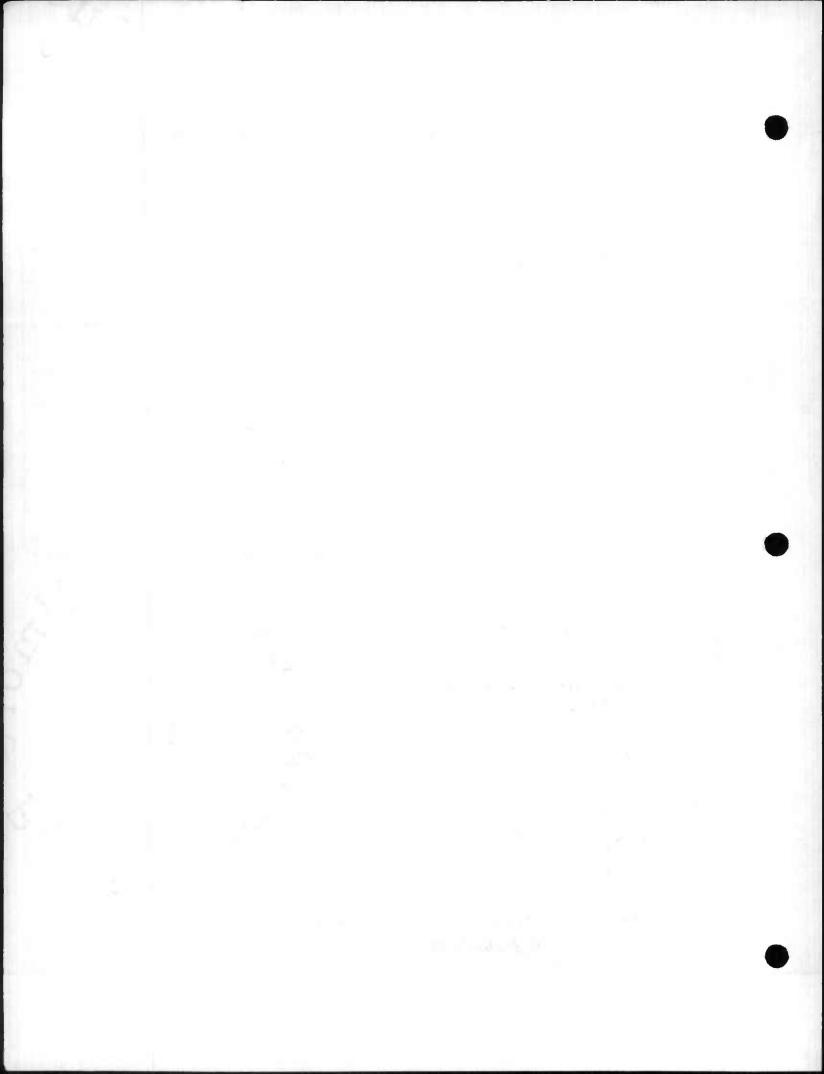
MATTHEW

31. DATE FILED (Month, Day, Year)

MAR 03 1995

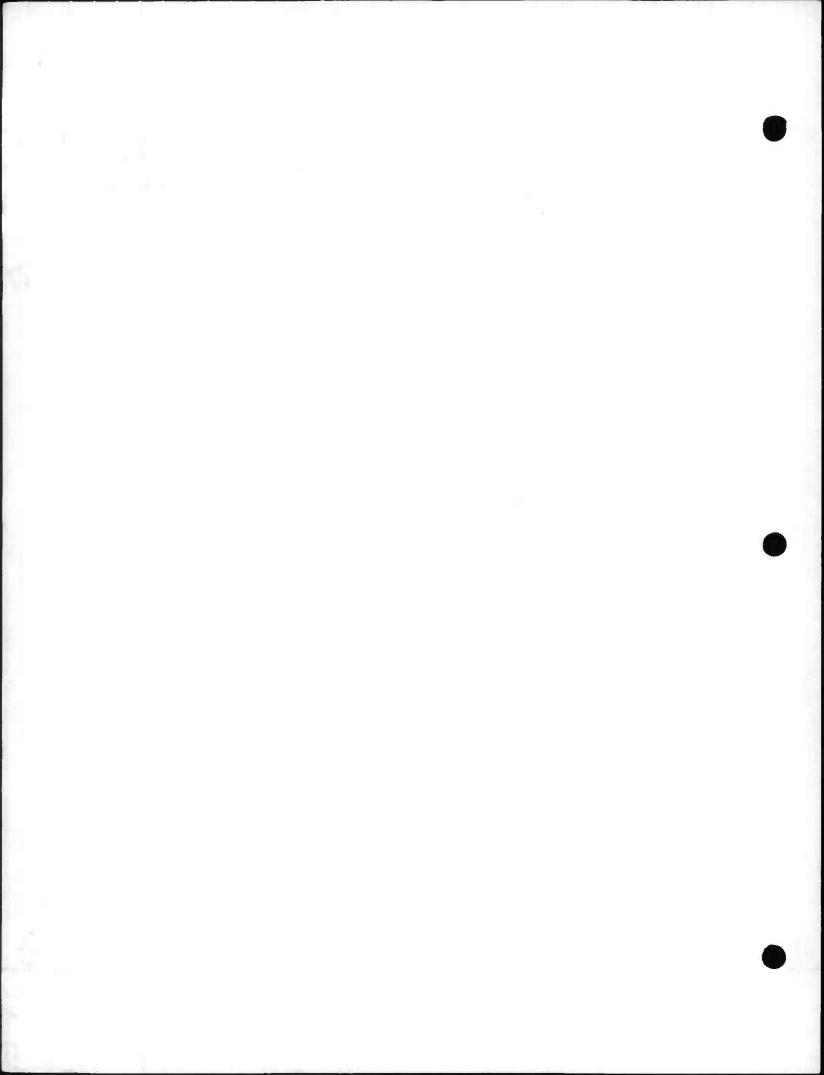
CATONSVILLE, MD

MAIDED



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		ENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) Alice Jane Rick	ard				2 DATE OF DEATH		3. TIME OF DEATH 7:00 A M		
	4. SOCIAL SECURITY NUMBER 216-74-7429	1 🗆 M 2 💢 F	62 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV . 18	0.1	BIRTHPLACE (State or Foreign Country) Maryland		
TOR	9a. FACILITY NAME (If not institution, give and Avalon Manor Homestoence of decement					on of DEATH Soc. COUNTY OF DEATH Washington				
DIRECTOR	10a. STATE AND 10b. COUNT	v hington	711.	TOWN OR LOCAT	1500	10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
FUNERAL	100. STREET AND NUMBER 411 S. Potomac S	treet	reet 10f. ZIP CODE			40		OF WHAT COUNTRY?		
ВҰ	11. MARITAL STATUS 1 Never Married 2 XMarried 3 Widowed 4 Divorced	FORCES? 1 YES 2 XNO			ENDENT OF HISPANIC ecify Cuben, Mexican, 2 XNO Specify:	ORIGIN? (Specify Yes Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: White		
COMPLETED	15. OECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. OECEDENT'S U (Give kind of wo life. Do NOT use	irk done during mo		16b. KIND OF BU	SINESS/INDUST	RY		
MP	Unknown 17. FATHER'S NAME (First, Middle, Lest)		Home	maker			wn home	e		
	Thomas Henry Ruc	l _r				elen Penn				
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a		ute Number, City or Tow		le)		
5	Thomas C. Rickar	d					agerstown, Md. 21740			
	20s. METHOD OF DISPOSITION 1 (X) Burial: 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	count from State	PLACEAND DATE OF PLACE AND DATE OF OTHER DATE OF THE PLACE AND DATE OF THE PLACE OF	Memoria	al Park 2	OATE 20c. LO	agerst	own. Marvland		
4 Donation 5 Other (Specify) Cedar Lawn Memorial Park 2+24-95 H 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnic 415 E. Wilson Blvd. Ha								ch Funeral Home		
	23. PART I. Enter the diseases, or shock, or heart feliure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	CONSEQUENCE OF)	n An	Harr		Iratory arrest,	Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. CLULFO has a CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d									
MEDICAL		ns contributing to deeth but		reaulting in the underlying cause given in Part I.			AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 JAO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (Chec					
	1 YES 2 AND 27. MANNER OF DEATH 1 Natural 5 Pending	25a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 26c. INJ	RK?	Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCUR	ED		
2 Accident Investigation 2 Accident Investigation 3 Suicide 6 Could not be building, atc. (Specify) 28e. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street City or Town, State,							and Number or Rural Route Number,			
COMPLET		ICIAN: To the best of my knowled						use(s) and manner as stated.		
B	29b. SIGNATURE AND TITLE OF CERTIFIE	R Tarle Mo			29c. LICENSE NUMB	ER	29d. DATE SK	GNED (Month, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON WE VASAWT DA	TO COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, F	rini)	MALE	is tow.	an w	21240		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE									



BALIIMORE, MARYLAND 21215-0020	th. Page 6 may be retained by the hospital or attending physician.
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2	0
ND	hospital
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\equiv	B
MAR	retained
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Y	may
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Σ	Page
ALI	nours after death.
n	after
	DOURS

DIVISION OF VITAL RECORDS, P.O. BOX 68760

RICHARD J. COLFER

FEB 2 7 1995

TO BE

		FOR STATE REGISTRAR	STATE OF MARYL			OF HEALT		MENTAL	HYGIEN	E	0,700	
		1. DECEDENT'S NAME (First, Middle, Last)							OF DEATN	9	3. TIME OF DEATN	_
10		WILLARD C	CLAUDE R	EEVE.	5		10	FERR		5. 19	95 10:05 P	M
10		4. SOCIAL SECURITY NUMBER		In yrs. last birthd	y) IF UNDER 1		DER 24 HRS.	7. DATE C	F BIRTN	-	S. BIRTHPLACE (State or Foreign	_
_		212-09-7741	1 1 M 2 □ F 70	g YR	MONTHS	DAYS HOURS		Feb.	20. 1	916	Iowa	
3 should		9a. FACILITY NAME (If not institution, give str			9b. CITY,	TOWN OR LOCA		-	20,		TY OF DEATH	
	E C	1 Hopewell Road			На	vre de	Grac	e		Har	ford	
1, 2,	DIRECTOR	RESIDENCE OF DECEDENT					OLUC			Tial	1014	
sabe	뿐	10a. STATE 10b. COUNTY		10c.	CITY, TOWN OF	LOCATION					10d. INSIDE CITY LIMITS?	
permit. Pages		Maryland	Harford		Havre	de Gra					1 TYES 2 TO NO	
Ded.	ERAL	10e. STREET AND NUMBER				10f. ZIP CO	ODE			10g. CITIZE	EN OF WHAT COUNTRY?	
physician. burial-transit		1 Hopewell Road					2107				S.A.	
physician. burial-tran	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED		AS DECENDENT yea, specify Cu				or No- 1	4. RACE — American Indian, Black, Whita, etc.	
	В	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES T		YES 2 N			450, 1911,		Specify:	
as se	ا ۵	15. DECEDENT'S EDUC	ATION	160 DECEMEN	T'S USUAL OC	CURATION		405	KIND OF BUS		White	_
al or atte	ETE	(Specify only highest grade of Elementary/Secondary (0-12)	completed)	(Give kind		iring most of wo	rking	100.	KIND OF BUS	INCOO/INDO	SINI	
pital ed fo	7	8	College (1-4 or 5+)	Welde	~				Stee	7		
retained by the hospital or 5 should be detached for unotified at once.	COMPLET	17. FATNER'S NAME (First, Middle, Last)		WCIAC		16. MC	OTHER'S NA	ME (First M	iddle, Maiden			_
be d	C	Virgil Green Reev	, ,						inato	,		
5 should	00	19a. INFORMANT'S NAME (Type/Print)	CS	19b. MAIL	ING ADDRESS	(Street and Numi					Corde)	_
5 st	임	Mrs. Georgia Reev	es			Road.						
page t be		20a. METHOO OF DISPOSITION	20b.	PLACEANDDA			Havre	OATE			ty or Town, Stata	_
Page 6 ma director, p		1 St Burlai 2 Cremation 3 Remo	val from State	otani orometoni	or other place!		Com	2/2			on. Maryland	
Page al din		21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	CERROTTY	22 N	AME AND ADDE	DECC OF EAC	TILLIE				_
death. Pag funeral di f. examiner		Man D	n: H:		/ Ta	rring-(erdeen	Cargo	Fune	ral H	ome,	P.A.	
after of the smoval.		23. PART I. Enter the diseases, or co	mnlications that caused	the death 5								
in in		ehock, or heert fallure. L	let only one ceuee on ea	sch lina.	o not enter t	ne mode of t	dynig, suci	i as coldi	ec or reepi	atory erre	Interval Between	
ion.		IMMEDIATE CAUSE (Finel disease or condition	A COMPANIA C	21500	0	1100					Onset and Daet	h
ted within 24 completely fill id, cremation, the event, the	1	resulting in death)	ARTERIOS O	CONSEQUENCE	//C	CAKDI	OVAS	CUA	R DI	SEASE		_
G P C	_				- 0.).							
e be execut sician and c rior to buri traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE	OF):							_
physician ne prior t	AT	ceuse. Entar UNDERLYING										
ertificat ing phy gjene p	Ĕ	CAUSE (Disease or injury that Initiated events	DUE TO (OR AS A	CONSEQUENC	OF):							_
5 5 E	F	resulting in deeth) LAST										
e death	Ö	PART II. Other electrices and disco-										
the py the sind N	¥	PART II. Other eignificent conditions			ng in the und	erlying cause	e given in i	Part i.	24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	ě.
gned by	EDICAL	CARCINONA	OF LUNG			_		- 1	1 YES 2	KNO	COMPLETION OF CAUSE DF OEATH?	
requires been sign of Heal	Σ							_			1 TES 2 NO	
law las be bept.	PHYSICIAN:	DID TOBACCO USE CONTR					CERTAIN	1 🗆		**-		
V: The cate h State C	호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D	OTHER:	<u> </u>	^					_
CIAN ertific the S	14S		1 Inpatient 2 ER/Outp	1212	4 - Nursi	ng Home 5	Realdenca	6 🗆 Other	(Specify)		. 1/1	
his c with ked,	표	27. MANNER OF DEATN 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	266.	TIME OF 2	MORK?		28d. DESC	CRIBE NOW IF	IJURY OCCU	RED	
MG PHYS After this eath with	B	2 Accident Investigation	AR BUACE OF MUNICIPAL	41.1		1 YES 2	I I NO				-	_
TTEND TOR: A after d	8	3 Suicide 8 Could not be datarmined	28a. PLACE OF INJURY building, atc. (Speci	— At home, ter ify)	m, street, factor	ry, offica			TION (Street a r Town, State)	nd Number o	Rural Route Number,	
OR AT DIRECT hours a	ᇤ	AA. CERTIFIED										
AL DI 72 hor	COMPL		IAN: To the best of my knowl									
JNER THIN THIN	Ö	2 MEDICAL EXAMINER	: On the besie of axamination	and/or investig	ation, in my op	Inlon, death occ	cured at the	time, data a	ind place, and	dua lo tha	cause(a) and menner as stated.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the TO THE FUNERAL DIRECTOR: After this certificate has been signed by the be filed within 72 hours after death with the State Dept. of Health and MaIMPORTANT: It Item 28 is marked, or Item 23 shows any Injun	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	DEPUTY	MEDIEAL	EXAM	NER 290. LI	ICENSE NUM	BER		29d. DATE	SIGNEO (Month, Day, Year)	
DE DE DE DE DE DE DE DE DE DE DE DE DE D	0	Exchand f. Colfr MD	HAR	FORD .	COUNT	V	DEME			FEB	WARY 25, 1995	7

ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. MEGISTRAR'S SIGNATURES

2013 TRAPPE CHURCH ROAD

DARLINGTON, MARYLAND

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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF I	IEALTH AND I	MENTAL HYGIE		
	8	4	oris 1	Reese			2. DATE OF DEATH February	1 9 1995	3. TIME OF DEATH 2:30AM M
2		579-32-0159	□ M 2X) F 68	In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) February	2,1927	BIRTHPLACE (State or Foreign Country) Washington DC
2, 3 should	TOR	90. FACILITY NAME (If not institution, give street Southern Maryland RESIDENCE OF DECEDENT	No. of the second secon		96. CITY, TOWN C	or location of de Iton	ATH	9c. COUNTY Princ	of DEATH ce George's
permit. Pages 1,	DIRECTOR	10a, STATE 10b, COUNTY	George's		y, TOWN OR LOCA				10d. INSIDE CITY LIMITS? 1 YES 2 ANO
菱	FUNERAL	6716 Botetourt D	rive		10	20744		U.S	OF WHAT COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	B≺	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES GIVE WAR OR OVER 1950-19	U.S. ARMED 2 NO	If yes, sp	ENDENT OF HISPAN ecity Cuban, Maxica 2 NO Spectly	IIC ORIGIN? (Specify Yon, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc. Specify: 'AUCASIAN
212	PLETED			(Give kind of a life. Do NOT us		on est of working Corp Navy Nur		USINESS/INDUS	TRY
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) Fred E. Rees	se, Sr.				ME (First, Middle, Maide		-
	TO B	19a. INFORMANT'S NAME (Type/Print) Robert C. Reese					Route Number, City or To		
THE WE WE THE		20a. METHOD OF DISPOSITION 1. Surial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	A	PLACE AND DATE (of disposition (Ne ther place) n Nationa	ene of Feb.	23 PATE 20c. L 995 Arl:	ocation - city ington,	or Town, State Virginia
death.		21. SIGNATURE OF FUNERAL SERVICE LICEN	St		6633 (old Alexa	undria Fer	ry Rd.	Home, Inc. Clinton, Md
X 68760 e executed within chours in and completely filled in to to burial, cremation, or re- timatic event, the medi	TION	Sequentially list conditions, if any, leading to immediate	Subarachr DUE TO (OR AS A Cerebral	noid Hemo	orrhage n		1 ae'candlac or ree∣	Pretory arrest	Approximate Interval Between Onset and Death 2 12 95 2 19 95
P.O. B tth certificat tending phy al Hygiene p or other	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):				
AL RECORDS, P. 1 law requires that the death of the attend Dept. of Health and Mertal H 23 shows any Injury, or	MEDICAL	PART II. Other significent conditions of					PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
一年 皇皇 馬	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IQSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:				
NG PHYSICIAL fer this certificate with the marked, or	PHY	27. MANNER OF DEATH 1 Netural 5 Pending	Zinpetlant 2 ☐ ER/Outpe 28a. DATE DF INJURY (Month, Day, Year)	28b, TIM	E OF 28c. INJ URY WO	URY AT RK?	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED
TTENDI TTENDI TTOR: A after d after d	TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28e. PLACE OF IN URY building, etc., Speci	— At home, ferm, a			28f. LOCATION (Street City or Town, State	and Number or F	Rural Route Number,
425	COMPLET	290. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	N: To the best of my knowled On the basis of examination	edge, death occurre	nd at the time, date	end place, end dua	to the cause(a) end mo	inner se stated.	nuse(s) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	BE	296. SIGNATURE AND TITLE OF SERVICES	Hear			29c. LICENSE NUM D09451		29d. DATE SI	ONED (Month, Day, Year) 23,1995
	10	30. NAME AND ADDRESS OF BERSON WHO CO Benjamin S. Pecsor	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,		ll Rd For	res-ville		
		FEB 2 8 1995	32. REGISTRANS SIGN	TURE Randall					

FOR 1 - STATE

_	REGISTRAN			PENIIL	CATE	OF	DEAL	п		REG. NO.			
	t. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF MONTH	OEATH DA	v	YEAR	3. TIME OF DEATH
	Emma N	Myrtle R	opka						February 22, 1995 2:35 a				2:35 a M
	4. SOCIAL SECURITY NUMBER	S. SEX	6. AGE (In yrs.	last birthday)	IF UNDER t		IF UNDER	$\overline{}$	2 DATE OF	HTOLE		8. BIRTH	PLACE (State or Foreign
	579-26-1377	1 🗆 M 2 💢 F	75	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb.	14,19	920	Countr	ew York
	9a. FACILITY NAME (If not institution, give st				9b. CITY, 1	TOWN O	R LOCATIO	ON OF DE				INTY OF D	EATH
9 R	Calvert Manor Nu	ne	2:		Ris	sing	Sun				C	Cecil	
[RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			10c. CITY, TOWN OR LOCATION						INA MINIST NITV			
DIRECTOR	Maryland	Cecil		100.01	., IOWN UR			maai					10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	OCCII				_	zip code		LL		10- 017	17EN 05 4	1 TES 2 X NO
FUNERAL	223 Blythedale B	Road				101.	ZIF CODE		21904		rog. CIT	U.S	
3	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S.	ARMED	13. W	AS DEC	ENDENT O	F HISPAN	IC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian.
	1 Never Married 2 XXMarried	FORCES? t [IF YES, GIVE WA		∑/NO	It :	yes, spe	2 XNO	n, Maxicar	n, Puerto Rica	n, etc.)		Black Specif	, White, alc. ly:
BY	3 Widowed 4 Divorced		¥										White
COMPLETED	ts. DECEDENT'S EDUC (Specify only highest grade	completed)		DECEDENT'S	work done du	rina ma	et of workin	g		D OF BUS			h
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Şt	atist	ical (Clei	ck .	y 1				L Cen	
M		two rears	V .	A. Cent	ral	tese			Per			Mar	yLand
8	17. FATHER'S NAME (First, Middle, Last) Thomas Sn	nith U.11					ts. MOTH		ME (First, Midd			l :	
BE	11 IOIIIAS 511 19a. INFORMANT'S NAME (Type/Print)	irei unit		19b. MAII IMO	AOORESS	Straw =	nd Number		orma E				
٩	Earl E. Ropka			223 B	Lytheo	dale	e Roa		Port D	eposi	it, 1	1aryl	
	20a, METHOO OF DISPOSITION 1 X Burlet 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	ovel from State	cemetery,	cremetory or o	ther plece)			2/2	0ATE 24/95			City or To	t, Maryland
	21. SIGNATIVE OF FUNERAL SERVICE JUCENSEE 22. NAME AND ADDRESS OF FACILITY												
	Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903 23. PART I. Errier the disserbe, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Apply								ome				
	23. PART I. Enfer the diseese, or c shock, or heart failure. I IMMEDIATE CAUSE (Final	complications that List only one caus	caused the	deeth. Do r Ina.	not enter ti	he mo	de of dyi	ng, auct	n aa cardiac	or reapi	ratory ar	reat,	Approximata Intervsi Batween Onset and Dasth
	disease or condition resulting in death) s. Quite MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):												
	DUE TO (OR AS A CONSEQUENCE OF):												
NO.	Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											-	
EK	cause. Enter UNDERLYING										İ		
필	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONS	SEOUENCE O	F):					-			
CERTIFICATION	resulting in death) LAST	d											
	PART ii. Other aignificant condition	s contributing to d	death but no	t reaulting	in the und	erlying	Cause o	iven in	Part i. 24	. WAS AN	AUTOPSV	24h	WERE AUTOPSY FINDINGS
EDICAL	CEREBROVA		_				,	,		PERFOR	MED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ED		SCUCHE	,,,,,	VEW/					_ 1	YES 2	NO NO		OF DEATH?
PHYSICIAN: M	DID TOBACCO USE C	ONTRIBUTE	TO CAL	JSE OF	DEATH	l YI	ES 🖂	NO	_				1 NES 2 NO
NA!	25. WAS CASE REFERRED TO MEDICAL								eck only one)				
Sic	EXAMINER? 1 YES 2XXNO	HOSPITAL:	ER/Outpatiant	3 DOA	OTHER:			a carrier	8 Other (S	pecify)			
Ĕ	27. MANNER OF DEATH	28a. DATE OF I	NJURY	28b. TIM	E OF 2	28c. INJ	URY AT		28d. OESCR		NJURY OC	CUREO	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	y, rear)	III.	M		RK? 'ES 2	ON [
	3 Suictda 6 Could not be	28a. PLACE OF building, a	INJURY — At	home, farm,	street, lactor	ry, offici			281. LOCATIO		and Numbe	or Or Rural F	loute Number,
COMPLETED	4 Homicide detarmined	January, a	(() () ()						Only Or A	own, State)			
2	29a. CERTIFIER to CERTIFYING PHYSIC	CIAN: To the beat of r	ny knowledge,	death occurr	ed at the tim	ne, data	and placa,	and dua	10 the cause(a) and man	mer as ats	rted.	
WO	one) 2 MEDICAL EXAMINE) and manner as stated.
	296, SIGNATURE AND TITLE OF CERTIFIER		/	. 1	121 (6)			NSE NUM					(Month, Day, Year)
BE	announcement of the Cole Cole (Cole Cole Cole Cole Cole Cole Cole Cole	X Mille	WHA	me 1	40		7)	45	244		•	2/2	2195
임	30. NAME AND AGORESS OF PERSON WH	O'COMPLETED CAUSI	E OF PEATH (TEM 27) (Type	Print)			/5				a ja	-170
	Suresh Dhanjani,	M.D., 20	Crai	gtown	Road,	, Po	ort D	epos	sit, Ma	aryla	and	2190	4
	3t. DATE FILED (Month, Day, Year)	32. REGISTRAF	'S SIGNATURE	E						_			
į.	FFR 2.4 1995 9	Julia Dherelso	x-Rardal	l									
	0												DHMH-18 Rev 1/89

DHMH-16 Rev 1/89

1, 2, 3 should

Pages 1

director, page 5 should be detached for use as the burial-transit

completely filled in by the funeral rial, cremation, or removal.

ysician and com prior to burial, (

been signed by the attending physician or, of Health and Mental Hyglene prior to

has be Dept.

certificate It

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After death

HOSPITAL OR ATTENDING PHYSICIAN: The law

requires that the death certificate be executed within

Items13,15,16a,16b,18 5-17-95 FilmG723 W.H.Per F/H

32. REGISTRAR'S SIGNATURE Davilson Randell

ITEMS: 10a,b,c,d,e,f, per informant G-723 5/22/95 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH February YEAR Delphine I. 7:40 Au K1210 20, 1995 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. lest birthday) 7. OATE OF BIRTH 6. BIRTHPLACE (State or Foreign 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 21914 Argentina March S 151-03-5980 HOURS 80 1 | M 2 XF 9e. FACILITY NAME (If not institution, give street and number 9c. COUNTY OF DEATH 95 CITY, TOWN OR LOCATION OF DEATH Medpointe Carcenter
RESIDENCE OF DECEDENT EIKTON cecil DIRECTOR 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY MORRIS Bear New Contle BUTLER Y YES 2 25 NO. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 157 KIEL 901 Clydesdale 19701 07405 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-FORCES? 1 YES 2 If yes, specify Cuben, Mexican, Puerto Rican, etc.)

157 YES 2 If NO Specify: 1 Never Married 2 Merried specify white BY Italian 3 🔀 Widowed 4 🔲 Divorced 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Birthing Elementary/Secondery (0-12) College (1-4 or 5+) Seam stressife +2 armen 8th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) UN KNOWN Crasan and notified at **BE** 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Aural Route Number, City or Town, State, Zip Code) 2 DE Dr. inda M. Lecke Clydesdale ear, å 20s. METHOD OF DISPOSITION
1 A Burlal 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State must Cedar Paterson Cam. 2-25-95 4 Donetion 5 Other (Specify) SN OF ENDERIAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Maid St. ElKton, mo. 21921 medical Visesses, or complications that caused the death. Do not enter the mode of dying, such se cardiec or respiratory arreat, Approximete ehock, or heart feliure. List only one cause on each line interval Between Onset end Deeth IMMEDIATE CAUSE (Fine) the disease or condition Carcinoma event. resulting in deeth) traumatic CERTIFICATION Sequentisity list conditions. DUE TO (OR AS A CONSEQUENCE OF): If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AWAILABLE PRIOR TO COMPLETION OF CAUSE Metastatic Carcinom to level shows any 1 YES 2 NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) flem EXAMINER? OTHER: 1 | Inpatient 2 | ER/Outpetient 3 | DOA raing Home 5 - Residence 6 - Other (Specify) 50 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. JNJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF marked, 1 Natural 2 Accident 5 Pending 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) FUNERAL DIRECTOR: After within 72 hours after dea TTANT: If Item 28 is in 3 Suicide 6 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL OR ATTO THE FUNERAL DIRECT
DE filed within 72 hours at IMPORTANT: If Itom 2 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, deeth occured at the time, date end place, end due to the cause(s) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE achders mo 123322 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SACHDEV ELKton North St md 31. DATE FILED (Morith, Day, Year) FEB 23 1995

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	1 - FOR STATE OF STAT	F MARYLAND / DE	EPARTMENT OF H		NTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last) Lawre		m, Rawlings	2.	DATE OF DEATH	YEAR	3. TIME OF DEATH				
	aurem		emay S		2 25	-1000	10:02P M				
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. lest birt	MONTHS DAYS	HOURS MIN.	DATE OF BIRTH (Month, Day, Year)	8. BIRTH Country	PLACE (State or Foreign				
	212-40-0607 1XXM 2 2		ras.		Dec 22 194		yland				
Œ				R LOCATION OF DEATH		9c. COUNTY OF D					
DIRECTOR	Anne Arundel Medical Ce	nter	Anna	polis		Anne Aru	unde l				
R	10e. STATE 10b. COUNTY		C. CITY, TOWN OR LOCATI	ION			10d. INSIDE CITY LIMITS?				
	MD Anne Arunde			polis			1 YES 2X NO				
FUNERAL	100. STREET AND NUMBER		101.	ZIP CODE		10g. CITIZEN OF W	HAT COUNTRY?				
)NE	1198 Hampton Road	DENT EVER IN U.S. ARMED	1 40 1110 0000	21401		United St					
	1 Never Married Married FORCES?	1 YES 2 YO	If yes, spe	ENDENT OF HISPANIC Cocify Cuban, Mexican, Po	ORIGIN? (Specify Yee o uerto Rican, atc.)	Black	— American Indian, , While, etc.				
ВУ	3 Widowed 4 Divorced	TE WAN ON DATES	1 🗌 YES	2 NO Specify:		Specif	White				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECED (Give to	ENT'S USUAL OCCUPATION ind of work done during mos NOT use retired.)	N t of working	16b. KIND OF BUSIN						
LE	Elementary/Secondary (0-12) College (1-4 of 10)	N 3+)	and the second of		D						
OME	17. FATHER'S NAME (First, Middle, Last)		lumber	40 140 140 140 140 140 140 140 140 140 1		c Works					
EC	Clifton Edward Rawling	s Sr		16. MOTHER'S NAME (umame)					
8	190. INFORMANT'S NAME (Type/Print)		AILING ADDRESS (Street on		na Lewis	State. Zip Code)					
5	Kathleen R. Rawlings		98 Hampton F				21401				
	20s. METHOD OF DISPOSITION 1 Surfel 2 Cremation 3 Removal from State	20b. PLACE AND	DATE OF DISPOSITION (Name	ne of	OATE 20c. LOCA	ATION — City or Tox	wn, Siate				
	4 Donation 5 Other (Specify)	والاللال	Cemete	ry 3/1/95	Anna	polis. A	Maryland				
	IT. SHOWAT UNE OF FURNISHED SERVICE CICCHISEE	1-11	22. NAME AND	O ADDRESS OF FACILIT	ฟohn M. T	aylor Fu	ineral Home				
	Elalun.	ac		uke of Glo			oolis, MD				
	23. PART I. Entar the diseases, or complications shock, or heart fellure. List only ona	that caused the death. cause on each line.	Do not anter the mod	la of dying, auch as	cardiac or reapira	tory arrest,	Approximate interval Between				
	IMMEDIATE CAUSE (Final disease or condition	0.1.1.	, ,				Onset and Death				
	resulting in death)										
_	trul i hungeaudion uncuern										
흔	Sequentially list conditions, If any, leading to immediate	TO (OR AS A CONSEQUEN	ICE OF):	Civ C	10000						
2	cause. Enter UNDERLYING CAUSE (Disease or Injury		•								
	that initiated events resulting in death) LAST	TO (OR AS A CONSEQUEN	ICE OF):								
CERTIFICATION	d										
AL.	PART II. Other significant conditions contributing	to daeth but not resul	iting in the underlying	ceuse given in Pari	I. 24a. WAS AN AL PERFORMI		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
8					1 YES 2	S	COMPLETION OF CAUSE OF DEATH?				
M	DID TODA CCO LICE CO. TODA CO.						1 - YES 2 - NO				
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL		YES LI NO LI	UNCERTAIN [
SICI	EXAMINER? HOSPITAL		OTHER:								
H	27. MANNER OF BEATH 280. OATI	OF INJURY 28	b. TIME OF 28c. INJU	5 Residence 6 RY AT 266	Other (Specify) 1. DESCRIBE HOW INJ	URY OCCUREO					
ВУР	1 Netural 5 Pending (Mon 2 Accident Investigation	h. Day, Year)	M 1 YE	ES 2 NO							
EDE	3 Suicide 6 Could not be 28e. PLA	E OF INJURY — At home, ting, etc. (Specify)	farm, atreet, tectory, office	281	LOCATION (Street and City or Town, State)	f Number or Rural Ru	oute Number,				
E	4 Homicide determined										
COMPLET	29e. CERTIFIER (Check only one)										
00	2 MEDICAL EXAMINER: On the beele	of examination end/or inves	tigation, in my opinion, de	ath occured at the Jime,	, date and piece, and o	due to the ceuse(e)	end menner ee stated.				
BE	29b. SYGMATINE DID TILE OF CERTIFIER	111		29c. LICENSE NUMBER	11 2	29d. DATE SIGNED	(Month, Day, Year)				
2	30. NAME AND ADDRESS OF BERSON WHO COMPLETED	CAUSE OF DEATH-(FTEM 27)	Alima (Hist)	THE ST	100	2/26	1141				
	205 Pidalla	ALL K	Transit	THE C	0 2/4	Color	\rightarrow				
	31. DATE FILED (Month, Day, Year) 32. REGISTED 28 1995	HAR'S SIGNATURE	J. Val	FINA	1017						
	LER S 8 1992 Aller q	Twolson Kardall					- 3				

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

ugene

MAR u Z 1995

Henry

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1995

3. TIME OF DEATH

11:40 AM

2. DATE OF DEATH

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		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEA	R F UNDER 24 HRS,	7. DATE OF BIRTH		DIOTALDI (107 (00000 000000
		219-20-6323	1 X M 2 F	67 YRS.	MONTHS DAY		(Month, Day, Year)		Country)	MD
pinous		9e. FACILITY NAME (If not institution, give a		07	Oh CITY TOW	N OR LOCATION OF DI	06-23-19			
S Sp	Œ	Harford Mem		al.				9c. COUNT		
2,	DIRECTOR	RESIDENCE OF DECEDENT	ioriai riospita	d I	па	vre de G	race		larfo	rd
Pages 1	Ĕ	10a. STATE 10b. COUNTY	1	10c. CIT	Y, TOWN OR LO	CATION			10	d. INSIDE CITY
28	붑	MD H	arford	1	На	avre de G	race		11	LIMITS?
permit.	ERAL	10e. STREET AND NUMBER				101. ZIP CODE	. 400	10a. CITIZE		T COUNTRY?
萝		USA								
5-0020 nding physician.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 X YES IF YES, GIVE WAR OR D	2 NO	If yes,	DECENDENT OF HISPAN specify Cuben, Mexica /ES 2 X NO Specify		or No — 14	Black, W Specify:	
215-0 attending se as the	ED E	15. DECEDENT'S EDUC	1945 – 19						White	
- = 5	ETE	(Specify only highest grade		180. DECEDENT'S (Give kind of a life. Do NOT us	work done during	ATION most of working	16b. KIND OF BU	SINESS/INDUS	TRY	
	ا تا	Elementary/Secondary (0-12)	College (1-4 or 5+)						_	
AND 2 the hospital detached to once.	COMPL	AT CATHEOUS MARKET (E) A AND A DO	2	CEO/	Owner	7			Equi	ipment Co.
/LA by the be det	8	17. FATHER'S NAME (First, Middle, Last)) ! = l= =t =			ME (First, Middle, Melden				
He be	H	Market and the second s	Richardson				garet P. N		_	
MARYLAND retained by the hospid 5 should be detached notified at once.	6	Mrs. Mary JoAnn	Richardson				Route Number, City or Tow		/	21070
		20e. METHOD OF DISPOSITION					Havre de			
ORE 6 may ector, pa		1 X Burlel 2 Cremation 3 Remo	oval from State Cen	netery, crematory or o	OF DISPOSITION ther place)	(Name of	DATE 20c. LO			
Page all direct	1	4 Donation 5 Other (Specify)	ENSEE IVIO	ountain (Christia	an Ch. Co	e 3/4	Joppa	1, Ma	aryland
ALTIMORE, death. Page 6 may be funeral director, page		N 10- ()						D 4	
A Sala		Vellean 2	I Lounge L	-	Hav	re de Gra	n Funeral	21078	-3197	7
Te at		23. PART I. Enter the diseases, pro	omplications that cause	d the deeth. Do r	not enter the a	mode of dying, suc	h as cerdlec or reep	ratory scres	t,	Approximate
- 0		IMMEDIATE CAUSE (Final	Liet only one ceuse on e	ecn line.						Onset and Death
· 李章	ľ	disease or condition resulting in death)	PROSTA	TE CAT	NCER	2				10 crass
ted within 24 completely fill ial, cremation; event, the			PROSTAT DUE TO (OR AS							10 1003
68760 executed with and complete burial, crem	z		EXTENS	IVE 1	META.	57AS15	•			,,
	CERTIFICATION	Manual and a contentions,	DUE TO (OR AS A	CONSEQUENCE OF	F):					150
BOX ficate be physician ne prior t ter traus	2	Cause. Enter UNDERLYING CAUSE (Disease or Injury	BRAIN			95/5				1 Tray
. # 0 5 2	H	that initiated events reaulting in deeth) LAST		CONSEQUENCE OF	,					
, P.O. eath certificate data Hygien y, or other	Ä	readiting in deetin) Exst	SEF515	JASPIK.	ATION					
the dear of the Menta	- 11	PART il. Other aignificent condition	a contributing to deeth b	out not resulting	in the underly	ring cause given in	Part I. 24s. WAS AN	ALITTOPEV	245 WE	RE AUTOPSY FINDINGS
RECORDS, requires that the de-	EDICAL	CACHEXIA					PERFOR	RMED?	AVA	MILABLE PRIOR TO MPLETION DF CAUSE
CC ires t			11/1001112	y copy	V 12-7		1 🗆 YES 2	□ NO		DEATH?
REC v requires been sign rt, of Heal	Σ	DID TOPACCO LICE CONTE	NIDITE TO CALICE O	E DEATH W					10	YES 2 NO
law las b Dept.	NAI:	DID TOBACCO USE CONTR	GIBUTE TO CAUSE C				4 🗆 📗		<u> </u>	
Z To El	길	EXAMINER?	HOSPITAL:	28. PLACE OF DEAT	OTHER:					
OF VIT PHYSICIAN: 1 his certificat with the Stat ked, or ite	PHYSIC	1 YES 2 NO 27. MANNER OF DEATH	1 M Inpatient 2 ☐ ER/Ouig 28e. DATE OF INJURY			ome 5 Residence				
	BY Pt	1 Natural 5 Pending Investigation	(Month, Day, Year)	28b. TIM	URY	INJURY AT WORK? YES 2 MO	28d. DESCRIBE HOW I	NJURY OCCUP	IED	
S & S S	8	3 Sulcide 6 Could not be determined determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Stele)								
DIVIS OR ATTE DIRECTOR hours afte										
로 기 시 등	COMPL		CIAN: To the best of my know							
HOSPITAL FUNERAL WITHIN 72 TANT: IF	Š I	2 MEDICAL EXAMINE	R: On the basis of examination	n end/or investigatio	n, in my opinion	, death occured at the	time, date end place, en	d due to the c	euse(e) en	d manner ee stated.
THE FU filed with	шШ	296. SIGNATURE AND TITLE OF CERTIFIER		140		29c. LICENSE NUM	IBER	29d. DATE S	IGNED (Mo	onth, Day, Year)
TO THE HOSPIT TO THE FUNERA De filed within 7	0 8	apphalone		ND		D 3185	6	1 2,	126,	195
	2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	estory	MD2100	47		,
	ŀ	31. DATE FILED (Month, Day, Year)								
		MAR u Z 1995	12. REGISTRAR'S SIGN	ardall						

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 8 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 fours after detail with the 52 state begin of Health and Mental Hygiere prior to burial, correction, or removal. To removal. In them 28 is marked or them 28 for howe any line was the trained for the trained for any filled propriets.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)			CERTII	ICATI		DEA	111	2. DATE OF	DEATH		3	TIME OF DEATH
	Amy W. Raison								Feb.	05		995	1532
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday)			IF UNDER	DER 1 YEAR IF UNDER 24 HRS. S DAYS HOURS MIN.			7. DATE OF E (Month, Da			8. BIRTHPL Country)	ACE (State or Foreign
	213-74-8757	1 🗆 M 2 💢 F		99 YRS.					Decemb		1, 18		Delaware
or	9a. FACILITY NAME (If not institution, give					OR LOCATI	ON OF DE	EATH			TY OF DEA		
DIRECTOR	Dorchester Gener	al Hospit	aı		U:	ambr	idge				Dor	chest	er
E C	10a. STATE 10b. COUNT	гү		10c, CIT	Y, TOWN	OR LOCA	TION					1	Dd. INSIDE CITY
PH	Maryland Dor	chester			Cambi	ridg	e					1	LIMITS?
AL	10e. STREET AND NUMBER			Tarrier I		10	H. ZIP COD				10g. CITIZ	EN OF WH	AT COUNTRY?
EB	818 Park Lane						216	13			US	A	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES				If yes, s	CENDENT (Decify Cubic NO	n, Maxica	NIC ORIGIN? (S in, Puarto Ricar y:	pecify Yea I, atc.)	or No-	Black, \	American Indien, White, atc. Black
ED	15. DECEDENT'S EDU (Specify only highest grad		16	a. DECEDENT'S	USUAL O	CCUPAT	ON		16b. KIN	D OF BUS	INESS/INDI	JSTRY	
	Elementary/Secondery (0-12)	College (1-4 or 5	+)	(Give kind of tille. Do NOT ut			ost of worki	ng					
MPI	8th		- 1	Farm l	Labor	rer			Fa	rmin	g		
COMPLET	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle				
BE	George Watson						Am		maiden				
2	19a. INFORMANT'S NAME (Type/Print)								Route Number, C				2
	Pauline K. For	eman				_		camb	ridge,				
1 M Burial 2 Cremation 3 Removal from State Competery, Grematory of other place Cambri Cambri								erion - City or Town, State bridge, Maryland					
	21. SIGNATURE OF FUNERAL SERVICE U	CERNET	_	0	22.	Ben Ben	nd addre	ss of fa Smit	h Fune	ral 1	Home		
	1/-					426			Street			Mary	land
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Cause (Disease or conditions, our consequence of): Cause (Disease or injury that initiated events) Cause (Disease or injury our to (or as a consequence of):											2042	
	PART II. Other significant condition	ne contributing to	deeth but	not resulting	in the u	nderlyln	ig ceuse	given in	Pert I. 24a	. WAS AN			ERE AUTOPSY FINDING
: MEDICAL	nove								10	PERFOR		C	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
A A	25. WAS CASE REFERRED TO MEDICAL					26. P	LACE OF O	EATH (Ch	eck only one)				
SIC	EXAMINER?	HOSPITAL:	XER/Outpetle	ent 3 🗆 DOA	STITE.	5:W	VV		6 Other (Sp	ac/fu)			-
Y PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF (Month, C	INJURY	26b. TIM	- 47	28c. IN.	JURY AT DRK? YES 2		28d. DESCRI		IJURY OCC	URED	
2 Accident 3 Suicida 4 Homicide 2 Description 3 Suicida 5 Could not be detarmined 2 Description 3 Suicida 6 Could not be detarmined 2 Description 2 Description 3 Suicida 6 Could not be detarmined 2 Description 3 Suicida 6 Could not be detarmined 2 Description 4 Homicide 2 Description 5 Suicida 6 Could not be detarmined 2 Description 6 Could not be detarmined 2 Des									te Number,				
		SICIAN: To the best of a					death occu	red at the	time, data and		dus to the	cause(a) a	
N N	1/1/1/1/1/1/1	10						LNSE NUI	WEEK				lonth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI Vinodrai Mehta,			Aurora		eet	D155 Ca		dge, M	D 2		6/95	
	·												
	31. DATE FILED (Month, Day, Year) FEB 1 7 1995	July do	weless-	Carolall,									

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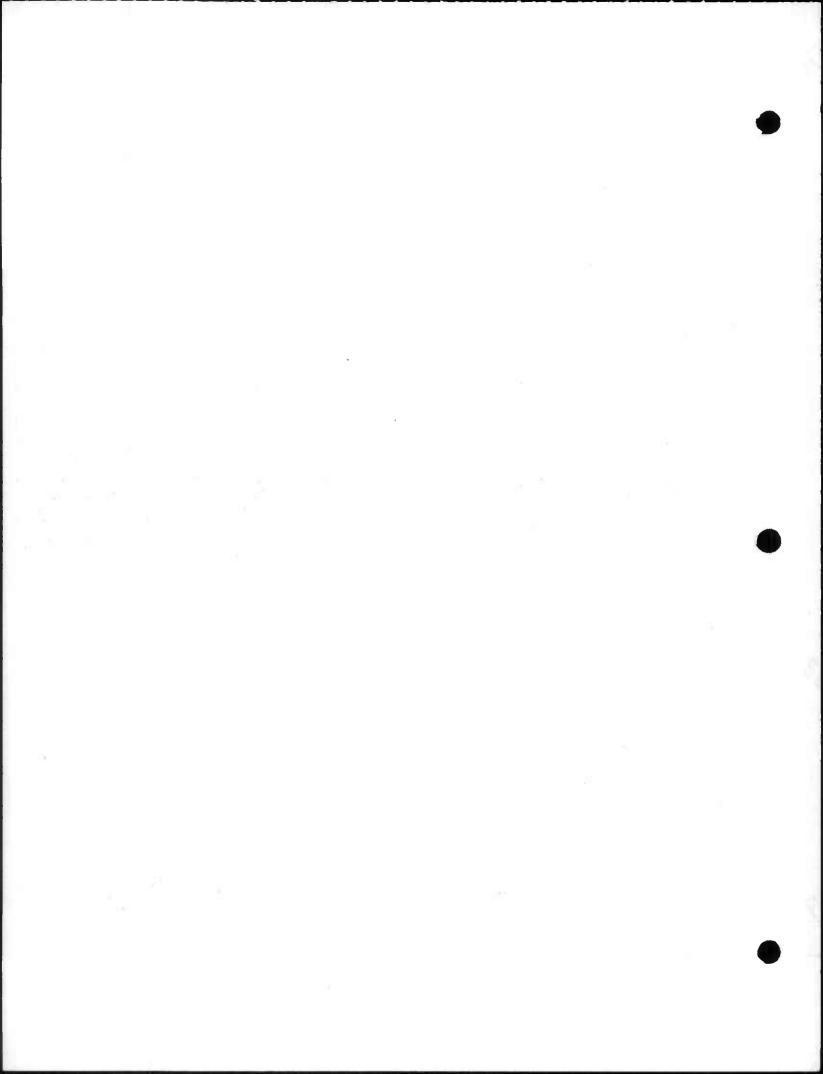
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE (F MARYLAND / DEPARTI	MENT OF	HEALTH /	AND	MENTAL	HYGIENE
	CERTIFIC	CATE O	F DEAT	Н		REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIE							
	1. DECEDENT'S NAME (First, Middle, Last)	h.	Riga:	2		2. DATE OF DEATH	26, 19	HEAR 3.	G 26 A M				
	217-42-0133	□ M 2 [XF 5]	YRS.	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BINTH (Month, Day, Year) Jun 15,	.943	Mary	CE (State or Foreign				
TOR	9a. FACILITY NAME (If not institution, give stree Shady Grove Adversioence of Decement				R LOCATION OF DE	EATH		gome					
DIRECTOR	Maryland Montgo	omery		own on Locat thersh				1. INSIDE CITY LIMITS? YES 2 NO					
FUNERAL	13801 Ranch P.	lace			ZIP CODE		10g. CITIZE	COUNTRY?					
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2 NO	If yes, spi	ENDENT OF HISPAT Helfy Cuban, Maxica 2 NO Specifi	NIC ORIGIN? (Specify) in, Puerto Rican, etc.) y:	Black						
COMPLETED		ION Inpleted) College (1-4 or 5+)	18a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mostired.)	N If of working	16b. KIND OF B							
OMF	12th Grade 17. FATHER'S NAME (First, Middle, Lest)		Assemb	Ter	48 MOTHER'S NA	Watkir	*****	nsor	ico.				
	Daniel Wash	nington					n Sumame) Brown						
TO BE	19a. INFORMANT'S NAME (Type/Print) (Hu Mr George A. Ric	usband)	19b. MAILING AD 13801	Ranch	nd Number or Rural i	Aoute Number, City or R	wn, State, Zip C	ig, N	0878 Id				
20e. METHOD OF DISPOSITION PARTHUM 2 Cremetton 3 Removed from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of park 3/3 Rockvi) Parklawn Memorial Park 3/3 Rockvi													
	21. SIGNATURE OF FUNERAL SERVICE LIGHT	In a way	den			eral Hon							
	23. PART I. Entar the diseases, or con shock, or haert failura. Lis	iplications that ceused	the death. Do not	enter tha mo	de of dying, suc	h es cerdiec or ree	piratory arres	st,	Approximate				
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Lung	Car	rees					Interval Between Onset and Daath 5 min 7/14				
TION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease Dr Injury thet initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):										
	PART II. Other algnificant conditions of	ontributing to death be	ut not resulting in t	he undariving	ceuee given in	Pert I. 24a, WAS A	N AUTOPSY	24h WE	RE AUTOPSY FINDINGS				
EDICAL						PERFO	PRMED?	AVA COI OF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?				
N.	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES		UNCERTAIN	V)EK		1 1	YES Z NO				
PHYSICIAN: MEDIC		OSPITAL:		THER:	5 Residence	6 ☐ Other (Specify)							
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJU	IRY AT	28d. DESCRIBE HOW	INJURY OCCU	RED					
2 Accident Acciden									Number,				
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINED.												
BE CO	290. SIGNATURE AND TITLE OF CONTURER	100	2mA	n my opinion, de	29c. LICENSE NUM				onth, Day, Year)				
٥	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Pri	Dinc	0/2	780	Mar	2 m	20,199				
	31. DATE FILED (Mointh, Day, Year) FFR 28 1995	32. REGISTRAR'S SIGNA	ardall			The Oil	One	1100	000000				



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,
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	hour	of be	10	E
	57 U	ly fill	ation,	ţ
	withir	plete	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	/ent,
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	tifica	d phy	iene	ther
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Samuel I. DeShay

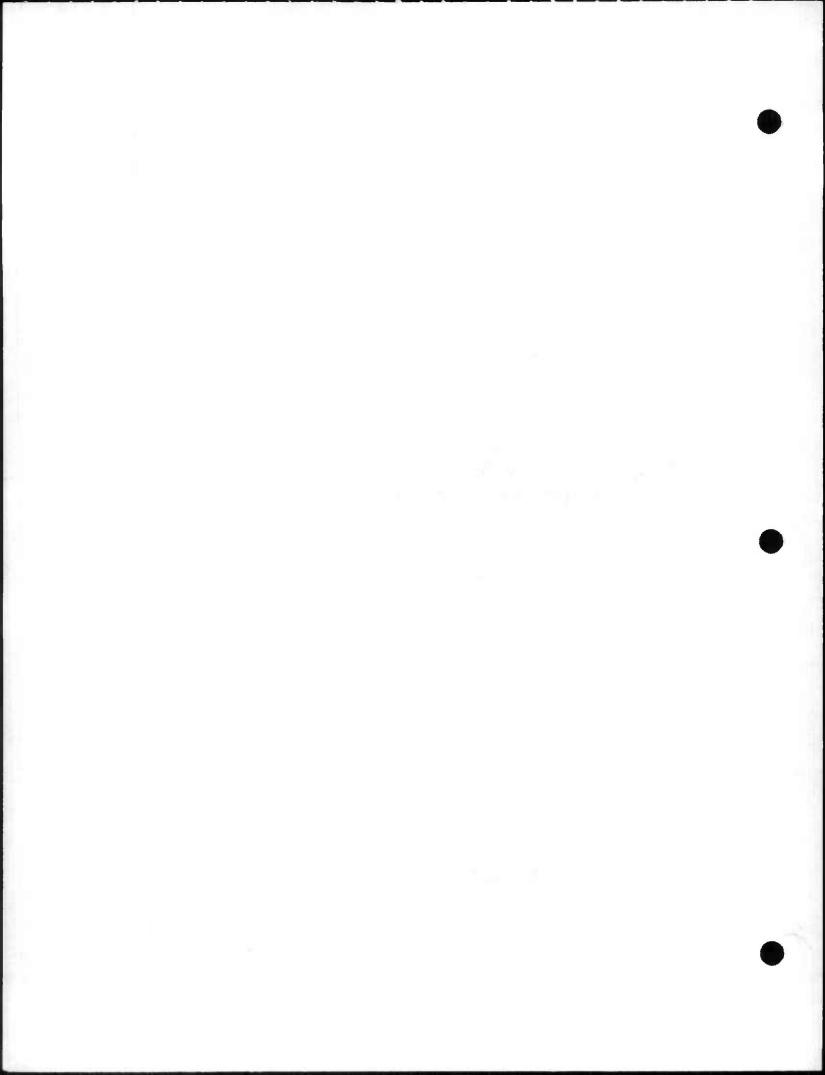
31. DATE FILED (MORITI, Day, Year)

MAR 02 1995

							95	07963		
	1 - FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Orah Albert					Februar	y22,19	995 4:00 p M		
	4. SOCIAL SECURITY NUMBER 218-16-0122	1 🗆 M 2 🔀 F	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 5		BIRTHPLACE (State or Foreign Country) Minnesota		
OR	90. FACILITY NAME (If not institution, give Washington Adv	rentist Hos	spital	Takom	a Park	EATH		y of DEATH itgomery		
E C	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y	10c, CIT	Y, TOWN OR LOCAT	TON			10d. INSIDE CITY		
L DIR	Maryland Mon	tgomery		koma Pa	ark			LIMITS?		
VERA	7707 Carroll	Ave.			20912			S.A.		
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Married 3 Number Married 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 X NO	If yes, sp	ENDENT OF HISPAI ecity Cuban, Maxics 2 NO Specif	NIC ORIGIN? (Specify 'sn, Puerto Rican, etc.) y:	Yes or No — 14	RACE — American Indien, Black, Whita, atc. Specify: White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Coffege (1-4 or 5+)	16a, DECEDENT'S (Give kind of v life. Do NOT us	USUAL OCCUPATION Work done during mose retired.)	ON st of working		USINESS/INDUS			
MP		1	Nurse				h Care	>		
6 111	17. FATHER'S NAME (First, Middle, Last) Herman E. S	Sauer			16. MOTHER'S NA Mart	tha Bor				
2	19a. INFORMANT'S NAME (Type/Print) Darrell H. Reich 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7707 Carroll Ave. Takoma Park, MD 20912									
	20e. METHOD OF DISPOSITION 1 Burlet 2 X Cremetton 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory of Other place) Metropolitan Crematory Of Policy Company Alexandria, VA									
2	Duya	A De	bach	254	Carroll	Takom I St. NW	Washi	eral Home, Inc		
	23. PART I. Enter the disease or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Severe	ach line.		da of dying, auc	h as cardiac or rea	piratory arres	Approximate interval Between Onset and Daath		
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	h. Hyperter DUE TO (OR AS Congesti	asion A consequence of Ve Heart A consequence of	n: Failure).					
MEDICAL C	PART II. Other algorificant condition Diabetes Mell		out not resulting i	in tha undarlying	cause given in		AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	F DEATH YE	S NO	UNCERTAIL	N		1 TYES 2X NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT							
PHYSICIAN:	1 TES 27 NO	1X Inpetient 2 ER/Out	patient 3 DOA	OTHER:	5 🗆 Residence	8 Other (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY WO	URY AT RK? 'ES 2 NO	28d. DEŞCRIBE HOV	/ INJURY OCCUI	4ED		
8	3 Suicide 6 Could not be determined	26s. PLACE OF INJURY building, etc. (Spe	r — At home, farm, a cify)	street, factory, office	,	281. LOCATION (Stree City or Town, Sta	nt and Number or te)	Rural Route Number,		
COMPLET		CIAN: To the best of my know						cause(s) and manner as stated.		
8	29b. SIGNATUSE AND TITLE OF CERTIFIE		V~	16	296. UICENSE NUI D1993	MOER	29d. DATE S	GIGNED (Month, Day, Year) ruary 23,1995		
	30. NAME AND ADDRESS OF PERSON WH	O COMBI ETED CAUSE OF DE	ATH STEM AT CAR	O.C.	4					

Samuel I. DeShay 7610 Carroll Ave. Suite #320, Takoma Park, MD 20912

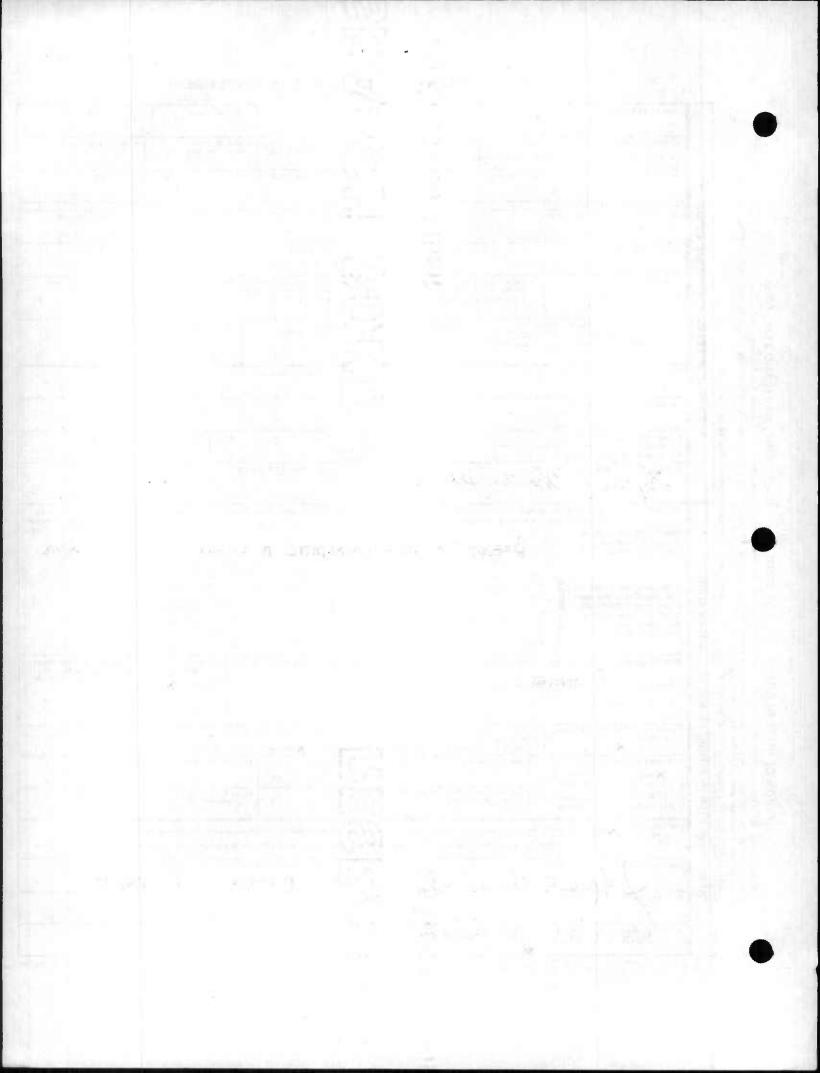
32 REGISTRAR'S SIGNATURE
This Studen Revolate DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	1 - STATE REGISTRAR	STATE OF MARY		MENT OF H		MENTAL HYGIEI				
1	1. DECEDENT'S NAME (First, Middle, Last)		162			2. DATE OF DEATH MONTH	DAY YEA	3. TIME OF DEATH		
- 3	PAULINE HIND RAN	IDOLPH					5, 1995			
1	4. SOCIAL SECURITY NUMBER 241-52-5184	1 □ M 2 ★ F	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		,1933 N	IRTHPLACE (State or Foreign DURTH CAROLINA		
DIRECTOR	98. FACILITY NAME (If not institution, give 6015 RED WOLF PI RESIDENCE OF DECEDENT			WALDO	R LOCATION OF DI	EATH	9c. COUNTY C			
EG	10a. STATE 10b. COUNT	ry	10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY		
		IARLES	WA	LDORF				1XXYES 2 NO		
RAL	10e. STREET AND NUMBER			101	. ZIP CODE			OF WHAT COUNTRY?		
FUNERAL	6015 RED WOLF PI	ACE 12. WAS DECEDENT EVER	IN U.S. ARMED	13 WAS DEC	20603	NIC ORIGIN? (Specify Ye		STATES		
B√	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		in, Puerto Rican, etc.)	6	BLACK				
COMPLETED	15. DECEDENT'S EOI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5 +)	16a. DECEDENT'S L (Give kind of w life. Do NOT use	ork done during mo	ON at of working	16b. KIND OF BU	JSINESS/INDUSTR	r		
AP	8TH GRADE	Conlege (1-4 of 5 4)	HOMEMAK	ER		Pl	RIVATE			
8	17. FATHER'S NAME (First, Middle, Last)		18. MOTNER'S NA	ME (First, Middle, Maide	Sumame)					
BE	RUFUS HIND					ATSON HIN				
유	19a. INFORMANT'S NAME (Type/Print) CAROLYN RANDOLPH	LIDICUT				Route Number, City or To				
	20a METHOD OF DISPOSITION	20	b. PLACE AND DATE O	F DISPOSITION (Na	me ol	WALDORF,	DCATION - City of			
	XX Burlet 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from State	ILLCREST	CEMETER	Y 3	/9/95 AH	OSKIE, N	NORTH CAROLIN		
	21. SIGNABLIAE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640									
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) BILENT CANCER - METASTATIC TO LUNCS DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
BY PHYSICIAN: MEDICAL CE	PART II. Other algorificant condition		but not resulting li	the undariying	g couse given in		RMED?	24b. WERE AUTOPSY FINDINGS AMAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch	eck only one)				
YSI	1 TES 2 NO	1 🗆 Inpatient 2 🗆 ER/Ou	tpetlant 3 DOA			6 Other (Specify)		No. of the last of		
ВУ РН	27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	INJU	M 1 1	RK? /ES 2 NO	28d. DESCRIBE NOW	INJURY OCCURE	D		
	3 Suicide 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJUF building, etc. (Sp	tY — At home, farm, at ecity)	treet, factory, offic		281. LOCATION (Street City or Town, State	and Number or Ru n)	iral Route Number,		
COMPLETED	onel	SICIAN: To the bast of my kno IER: On the basis of examinati						se(s) and menner as stated.		
TO BE C	296. SIGNATURE OF CERTIFIE	alum.	40	M	29c. LICENSE NUI		29d. DATE SIG	NED (Month, Day, Year)		
		RAMS, M.D.	#1134		ROOKE S	QUARE SU		ORF, MD .03		
	31. DATE MAR 10 6 1995	at nedistrian's sign	20 The Hall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Durs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

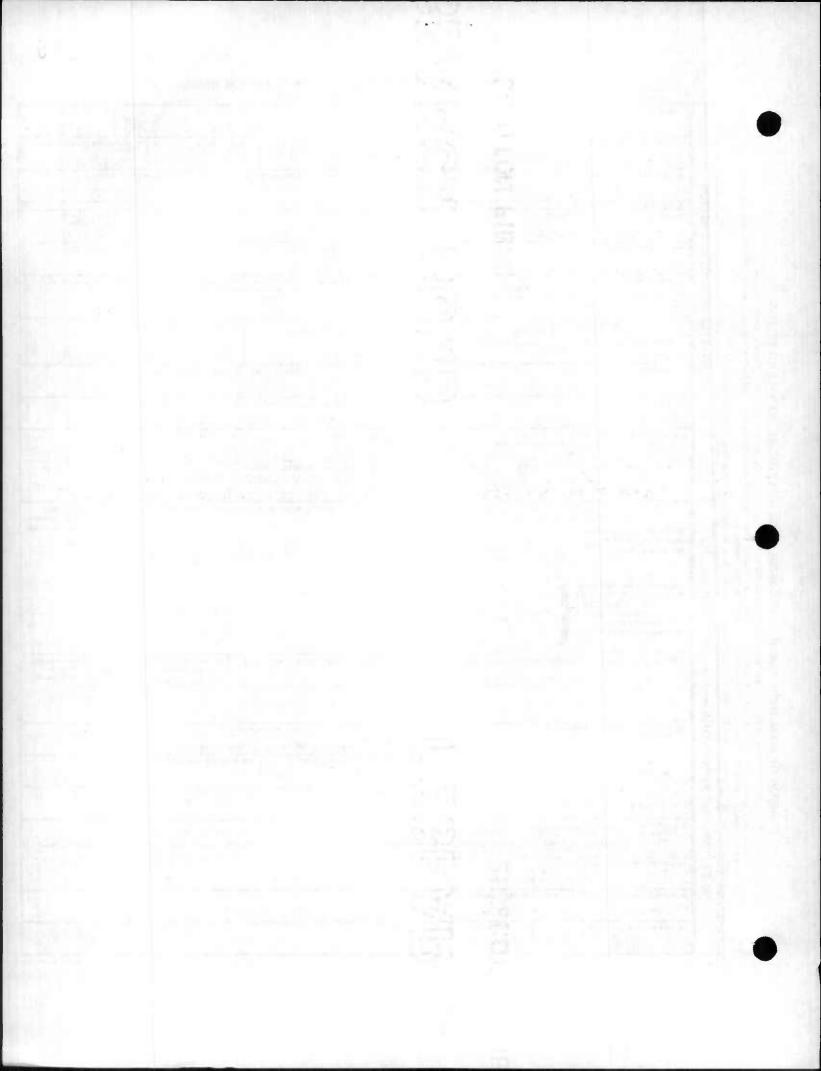
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR

	REGISTRAR		CE	-niir	ICALE	· UF	DEA	I II	F	REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Last) Robert Carr	oll Rick	etts						2. DATE OF MONTH March	_ DA	v 19	995°	3. TIME OF DEATH 3:30 pm
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. las	t hirthday)	IF UNDER	1 VEAR	IF UNDER	24 HRS					PLACE (State or Foreign
	216 - 10 - 1205	1 🔀 M 2 🗌 F	77	YRS.	MONTHS	DAYS	HOURS	MIN.	April	w. Yearl	1917	Country	ryland
	9a. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY,	TOWN	OR LOCATI	ON OF DE				NTY OF D	
Œ	4011 Sandy Spring	Road			Bur	ton	svill	le le		Montgomery			
2	RESIDENCE OF DECEDENT	ROGG			Dur		3V 111				1101	regon	icr y
Ĭ	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	, TOWN OR LOCATION							10d. INSIDE CITY
5	Maryland Monto	omerv		Bin	ctons	consville							LIMITS?
	10e. STREET AND NUMBER	J02 7		1 200	101, ZIP CODE						ton CET	ZEN OF W	HAT COUNTRY?
FUNERAL DIRECTOR		D = = 3			20866								nai coominii
빌	4011 Sandy Spring Road 20										USA		
5	11. MARITAL STATUS 1 Never Married 2 Married		T EVER IN U.S. AR		13. 1	MAS DEC	ENDENT C	OF HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RACE Black	— American Indian, White, etc.
ВУ	3 X Widowed 4 Divorced	IF YES, GIVE W					2 X NO			.,,		Specif	y:
													ite
E I	15, DECEDENT'S EDUC (Specify only highest grade)		(G	ive kind of I	Work done			na	16b. KIP	OF BUS	INESS/INE	USTRY	
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+	Alden	Do NOT us	se retired.)								
COMPLETED	Grade 6		Owi	ner /	Ope /	rate	or		As	phalt	Pav	ring	Company
Ö	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First, Midd	le, Malden S	Surname)		- " " - "
	Robert Ricketts						Ler	na Sp	peck				
BE	19a, INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS	(Street a			Route Number, (City or Town	State Zir	Code	
2	Janice Pattison B	roum		11/0	12+h	Str	root	La	urel,	Maxuz	back	2070	7
	20s. METHOD OF DISPOSITION	LOWII	20b. PLACE					, Dat		20c. LOC			
	1 X Buriel 2 Cremation 3 Ramo	rval from State	cemetery, cre	metory or o	ther plece)		inia Oi		1				*
	4 Donation 5 Other (Specify)	euces .	Unio	n Cer		_	ND ADDRE		3/8	Burt	const	/11TE	, Maryland
	. 6111-11-1	1) 111							eral H	ome,	P.A.		
	Vol of Steep X	July .							ve. La				d 20707
	23. PART I. Enter the diseases, or c	omplications that	ceused the de	eth. Do I									Approximate
	ahock, of heart fallure. I	lat only one cau	se on each line										Intarval Between
	IMMEDIATE CAUSE (Final disease or condition	<u></u>		y Artery Disease									Onset and Death
	resulting in death)	LOVO	naryr	MIE	1.4	015	.cq s	C					Years
- 1	The Section of Section												1
Z	Sequentially list conditions,	Hype	rtensio (OR AS A CONSEC	n									Years
Ĕl	If any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
CERTIFICATION	CAUSE (Disease or Injury												
#1	that initiated events resulting in deeth) LAST	OUE TO	(OR AS A CONSEC	DUENCE O	F):								
띮	resulting in deetil) CAST	l											
	PART II. Other algolificant conditions	contributing to	death but not r	eeuiting	In the un	decivin	a coules	niven in	Part I 24	. WAS AN	AHTOBOV	1 045	WERE AUTOPSY FINDINGS
<u>র</u> ।	Cerebrovascula			caciting	iii tije Gii	Carry	a cause ;	Aisen III	rait i. 24	PERFOR		240.	AVAILABLE PRIOR TO
EDICAL	CETEBIONOVIBLADO	V CISCASO							1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
ME													1 TYES 2 THO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					26, Pt	ACE OF D	EATH (Ch	eck only one)				
Sic	1 VES 2 NO	HOSPITAL:	ER/Outpetlent 3	□ DOA	OTHER		5 NA	esidence	6 Other (Si	pecify)			
<u></u>	27. MANNEB OF DEATH	26s. DATE OF		26b. TIM		26c. INJ	URY AT		26d. DESCRI		JURY OC	CURED	
	1 Netural 5 Pending	(Month, D	ny, Year)	INJ	JURY M	WC	PRK?	∃ NO					
B	2 Accident Investigation	28e. PLACE O	F INJURY — Ai ho	me ferm	street fact		_		281, LOCATIO	W /Ctmat a	and Massachus	or Premi B	Inute Municipal
	3 Suicide 6 Could not be 4 Homtcide detarmined	building,	etc. (Specify)	, ,,	stroot, ract	ory, orne				own, State)	nu riumow	Or Hurar A	oute Number,
	A. A. A. A. A. A. A. A. A. A. A. A. A. A												
₫	(Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, de	ath occurr	ed at the H	lma, data	and place	, and due	to the cause(e) and man	ner as stat	led.	
COMPLETED	0/10) 2 MEDICAL EXAMINER	: On the basis of a	camination and/or i	Investigation	on, in my o	pinion, d	leath occur	red et lhe	ilme, data and	place, and	d due to If	ne cause(a)	and manner as stated,
C I	29b. SIGNATURE AND TITLE OF CERTIFIER	20					29c, LICI	ENSE NU	#BER		29d. DAT	E SIGNED	(Month, Day, Year)
(C)	Total Date State S												
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITE	M 271 (Time	Print)	_		_	-		-		
	DAVID M- BRIG	-LIMA	7600	CA	RRU	LL	AVE	. To	AKOMI	4 PA	ek	my	
	31 DATE Ell EQ (Month Day Mar)		COUNTAINED S'D								21		
- 1	Millit o 1 100												



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	cal examiner must be notified at once.
VG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	ter this certificate has been signed by the attending physician and completely filled in by the fi ath with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	, or Item 23 shows any I
TO THE HOSPITAL OR ATTENDING PHYSICIA!	TO THE FUNERAL DIRECTOR: After this combe filed within 72 hours after death with	IMPORTANT: If Item 28 Is marked

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC			MENTAL HYGIENI REG. NO.	E					
	1. DECEDENT'S NAME (First, Middle, Last)			JANE OF	DEATH	2. DATE OF DEATN		3. TIME OF DEATN				
	NELLIE	PEARI.		RAT	JEC .	MONTH DA		3:00 P M				
	4. SOCIAL SECURITY NUMBER	S. SEX 6. AGE (IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	A BIRTH	PLACE (State or Foreign				
	232 26 0742		3Z YRS.	ONTHS DAYS	HOURS MIN.	March 6,1	912 Wes	st Virginia				
DIRECTOR	9e. FACILITY NAME (If not institution, give standard HOSI RESIDENCE OF DECEDENT		CUMBERLAND Sc. COUNTY OF DEATH ALLEGANY									
REC	10e. STATE 16b. COUNTY		10c. CITY,	TOWN OR LOCAT	ON		10d, INSIDE CITY					
	Tramp.	nire	Ro	mney			1 TYES 2 X NO					
FUNERAL	100. STREET AND NUMBER 70 Potomac A	venue		10f.	26757		U.S.A					
N N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DEC	ENOENT OF NISPAN	IIC ORIGIN? (Specify Yes						
ВУ Г	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 XINO ATES	If yes, spe	cify Cuben, Mexice 2 NO Specify	n, Puerto Rican, elc.)	Black, White, etc. Specify: White					
ED	15. DECEDENT'S EDUC (Specify only highest grade	ATION Completed	18e. DECEDENT'S US			16b. KIND OF BUS						
COMPLETED	Elementery/Secondary (0-12) N/A	life. Do NOT use	•	t or working	Rest	aurant						
	17. FATHER'S NAME (First, Middle, Last) Leslie Ever	ett	<u> </u>			ME (First, Middle, Meiden S	Sumame)					
TO BE	19e. INFORMANT'S NAME (Type/Print) Ray H. Raines		196. MAILING A	DDRESS (Street a		Romney, W	,					
	20e. METHOO OF DISPOSITION	206	PLACE AND DATE OF				CATION — City or To	wn. State				
	1X Buriel 2 Cremation 3 Remo	F	benezer					, WV				
	21. SIGNATURE OF FURIERAL SERVICE LICE	moan		Shafi 230 I	er Funer Cast Mair	al Home, I	Inc. ney, WV	26757				
	23. PART I. Entar the diseases, or c	omplications that caused	tha death. Do not	antar the mod	la of dying, suci	as cardlec or respir	retory arrest,	Approximate				
	ahock, or heart fallura. List only one cause on each line. IMMEDIATE CAUSE (Final											
	disease or condition resulting in death) a. ACTIVE HAS TROINTESTINAL BLEEDING DUE TO (OR AS A CONSCOUENCE OF):							7 days.				
NO	Sequentially list conditions,			ENAL	ULC	ER		UNKNOWN				
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING											
	that initieted events											
CER	Testitude in death) Exci	resulting in death) LAST										
AL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS AMBILIARY FRIOR TO											
MEDIC		Severt CHRONIC OBSTRUCTIVE LUNG VISCABL 1 YES 2 NO COMPLETION OF CAUSE										
AN AN	25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERIAIN	I LIF						
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Sinpatient 2 ER/Outp		THER:	5 Residence	S Other (Specify)						
BY PHYSICIAN:	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c, INJU	IRY AT	28d. DESCRIBE HOW IN	JURY OCCURED					
B	1 Matural 5 Pending 2 Accident Investigation	50 5V 105 05 W W		M 1 🗆 Y	ES 2 NO							
TED	3 Suicide 8 Could not be determined											
COMPLET	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.											
S S	one) 2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) end menner as stated.											
E E	29b. SIGNATURE AND TITLE OF CERTIFIER	(Dyn			29c. LICENSE NUM	(a 3 8	29d. DATE SIGNED (Month, Day, Year)					
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pr	int)	0 - 4	- / 0	FEBRUA	m1 - 7.1178				
	SATURNINA (W. FRO	STBURG	PLA:	A FROSTB	URZ M	D 71235				
	31. DATE FILED (Month, Dey., Year)	32. REGISTRAR'S SIGN	Rarball		4							
	* FD % A 1333											

¥ 1.

31. DATE FILED (Month, Day, Year)
MAR 14 1995

ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/14/95 t.t

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF	HEALTH AND	AND MENTAL HYGIENE H REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH							
	DAVID	Curtis		RYAN		MARCH	0 1		9 5	10:00	F		
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day	SIRTH v. Year)	8.	BIRTHPL Country)	ACE (State or Foreig	ın		
	220-78-5105	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	YRS.			Jan.	14,19	957	Mar	yland			
l œ	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY									
DIRECTOR	WASHINGTON (CO.HOSPITAL		HAGERS	STOWN			WASH	IING	TON			
	10s. STATE 10b. COUNT		10c. CIT	Y, TOWN OR LOCA		10d. INSIDE							
		Vashington		Hagers	stown		YES 2 NO						
ERAL	100. STREET AND NUMBER 212 AB Buena Vis	ta Arranza		10	101. ZIP CODE 10g. CIT					AT COUNTRY?			
FUNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	IIIS ADMED	12 WMC OF	CENDENT OF HISP	ANIC ORIGINA M-			ISA	. Construction of the cons			
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, s	pecify Cuban, Maxie S 2 00 NO Spec	cen, Puerto Rican		W NO- 14	Black, \	- American Indian, White, atc.			
BY	3 Widowed 4 Divorced			'	o I W I I I I I I I I I I I I I I I I I	ary.			Specify: Whi	te			
TED	15. DECEDENT'S EDI (Specify only highest grad	UCATION le completed)	(Give kind of	USUAL OCCUPATI work done during m	ION lost of working	16b. KINI	D OF BUSIN	NESS/INDUS	TRY				
PE	Elementary/Secondary (0-12)	College (1-4 or 8+)	We. Do NOT u	er emplo	oued								
COMPLET	17. FATHER'S NAME (First, Middle, Last)			01 011.00		IAME (First, Middle	. Maiden Su	ımame)			_		
ш	George David Rya	เท				F. Wil							
TO B	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rura	l Route Number, C	ity or Town,	State, Zip Co	ide)				
-	George Ryan		108 B	irch Kno	oll, Hage	erstown	, <i>Md</i> .	2174	10				
	20e. METHOD OF DISPOSITION 1												
	1 W Burlis 2 Cremation 3 Removal from State Competery, crematory or other place Rest Haven Cemetery 3-4-95 Hagerstown, Maryland												
	MTNNTCH FUNFRAT HOME												
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate												
	ahock, or heart failure.	complications that caused. List only one cause on e	tha death, Do i ach ilne.	not antar tha me	oda of dying, au	ch as cardiac	or respira	tory arrea	t,	Approximate interval Betw	100		
	IMMEDIATE CAUSE (Final disease or condition							Onset and De	natt				
	resulting in death)	a. ASTHMA DUE TO (OR AS A	CONSEQUENCE O	F):									
z		b .											
FICATION	Sequentially ilet conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):											
2	cause. Enter UNDERLYING CAUSE (Disease or injury	C	UE TO (OR AS A CONSEQUENCE OF):								_		
듄	that initiated events resulting in death) LAST		OUNDED COLINGE O	,	,					İ			
CE		d								1	_		
CAL	PART II. Other aignificant condition	ns contributing to death b	ut not resulting	in the underlyin	ng cause given in	n Part I. 24e.	PERFORM	MED? AVAILABLE PRIOR		MILABLE PRIOR TO			
MEDIC						1)2	FYES 2	NO		OMPLETION OF CAUS F DEATH?	E		
2	DID TOBACCO USE CONT	DIDLITE TO CALISE O	E DEATH VI	C D NO E	T UNICEDTAL				1	YES 2 NO			
IAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			IN L		-					
SICI	EXAMINER? 1 , YES 2 NO	HOSPITAL: 1 Inpatient 2 Proute		OTHER:		6 - Oth (0	-16.1						
р ву рну	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	6 ☐ Other (Specify) 28d. DE\$CRIBE HOW INJURY OCCURED				_				
	1. Netural 5 Pending 2 Accident Investigation	1145		ORK? YES 2 NO									
	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, factory, offic	Ce	28f. LOCATION City or Tox	(Street and	1 Number or	Rural Rou	te Number,			
ETE.	20 - OFFICIER												
COMPLET		SICIAN: To the best of my knowl											
8	2 X MEDICAL EXAMIN	ER: On the basis of error nation	and/or investigation	n, in my opinion, i	death occured at th	e time, data and p	place, and	due to the c	ause(s) a	nd manner as stated	1.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	4961			29c. LICENSE NU					Ponth, Day, Year)			
0		0			O.C.M.	. E .		MAR	CH	02,1995)		
임	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF DE	TH /ITEM OF /T-	Delett							_		

DHMH-16 Rev 1/89

111 PENN STREET, BALTIMORE, MARYLAND 21201

68760,
BOX
P.0
RECORDS
OF VITAL
DIVISION

	ermit, Pages 1, 2, 3 should		
ospital or attending physician.	thed for use as the burial-transit p		e.t
mounts after death. Page 6 may be retained by the hospital or attending physician	as been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pen		iner must be notified at once.
acuted within a nouns after death.	nd completely filled in by the funer	burial, cremation, or removal.	ed, or Item 23 shows any injury, or other traumatic event, the medical examiner must be noti
res that the death certificate be ex	igned by the attending physician ar	ealth and Mental Hygiene prior to	rs any injury, or other trauma
ATTENDING PHYSICIAN: The law requir	After this certificate ha	death with the State D	s marked, or item 23 show
TO THE HOSPITAL DR ATTEN	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after	IMPORTANT: If item 28 is marked

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH 3. TIME OF DEATH					
	ROY E. SWIC	!K				FED	. 2	4 199	5 1945 M			
	4. SOCIAL SECURITY NUMBER	CIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday)							BIRTHPLACE (State or Foreign Country)			
	236-01-4181	236-01-4181 1 M 2 F 82 YRS. MONTHS DAYS HOURS MIN. 90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE						July 29, 1912 Ohio				
H	PENINSULA REGIONA	EATH		9c. COUNTY OF DEATH WICOMICO								
DIRECTOR	RESIDENCE OF DECEDENT			SALIS								
뿐	10e. STATE 10b. COUNTY	f	10c. CITY, TO	OWN OR LOCATIO	ON				10d. INSIDE CITY LIMITS?			
LD	Virginia Acc	omack	Captai	ins Cov	e - Gree	enback	ville		1 TYES 2 NO			
FUNERAL	37240 Main Sail Court (P.O.Box 70) 23356							USA				
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED		NDENT OF HISPAI			Yea or No.— 14. RACE American Indian.				
BY F	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 TYES IF YES, GIVE WAR OR DA	2 XINO		olfy Cuben, Mexice P NO Specif		en, atc.)		Black, White, etc. Specify:			
		0.071011		!	21				white			
1	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind of work life. Do NOT use rel	done during most	of working	16b. Ki	ND OF BUS	SINESS/INOUS	TRY			
P.	1 1	College (1-4 or 5+)	_Civil Ser	ovice F	mplowoo		FHA	Λ.				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		-CIVII SEI	VILE I	18. MOTHER'S NA	ME (First, Mid						
BE (Grover C. Swick				Myrt1							
2	190. INFORMANT'S NAME (Type/Print) Ethel C. Swick				d Number or Rural		,					
	200. METHOD OF DISPOSITION	20h			Greenba	ACKV11	_					
	20b. PLACE AND DATE OF DISPOSITION 1 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemeltery, crematory or other place) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State											
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	o Billour	22. NAME AND	AODRESS OF FA	CILITY		_110WOO	ay raryrana			
	1 Scatt S	Melan			N FUNERA			26	2 01051			
	23. PART i. Enter the diseases, or c	complications that caused	the death. Do not a	anter the mod	Box 64	h as cardia	MOKE	ratory arrest	land 21851			
	ahock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset and Daeth											
	disease or condition resulting in death) . aprinction Pneumonic questre											
	DUE TO (OR AS A ZONSEGUENCE OF):											
NO	Sequentially list conditione, ff any, leading to immediate Due to (or as a consequence of):											
CAT	cause. Enter UNDERLYING											
HE I	that initiated events	OUE TO (OR AS A	CONSEQUENCE OF):									
CERTIFICATION	resulting in death) LAST d											
AL (PART ii. Other eigniticant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY ENDINGS											
DIC	Hypogrituitorism 1 yes 2 5400							AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?				
MEDIC	COPD,	ETOH A					,		1 TYES 2 NO			
PHYSICIAN:	DID TOBACCO USE CONT				UNCERTAIL	и 🗆 📗						
Sic	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HQSPITAL:		HER:	200							
HYS	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF		5 Reeldence			NJURY OCCUR	FO			
	Natural 5 Pending	(Month, Day, Year)	INJURY	M 1 YE	K7	200. 0200.	LDE TION II	WOM GOODN				
D BY	3 Suicide 6 Could not be	2 Accident 1177931981011					281. LOCATION (Street and Number or Rural Route Number,					
COMPLETED	4 Homicide determined					City or i	own, State)					
<u>P</u>		CIAN: To the beet of my knowle										
S	one) 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and menner ee stated.								puse(e) and menner ee stated.			
BE	296. SIGNATURE AND TITLE OF CENTIFIER			29c. LICENSE NUM	a contract of the contract of			GNED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO	TH (ITEM 27) / Time Prin	t)	D365	46		7 2	125/85				
			Z ND		Rues	redo	L Di	SA	luley My			
3	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA						- 0				
1	MAR 01 1393	1- Barrell Board							$\overline{}$			

		1 - FOR STATE REGISTRAR	TATE OF MARYLAN	ND / DEPAR	TMENT	OF H	EALTH DEAT	AND ME	NTAL HYGIEN	E			
		1. DECEDENT'S NAME (First, Middle, Last)						2.	DATE OF DEATH		3. TIME OF DEATH		
		Barbara Lee Smith						2 2	<u> </u>	95 9:00 A M			
Þ		217-30-5244	0-5244 1 M 2 XF 57				IF UNDER 1 YEAR IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) 2 / 27 / 38		BIRTHPLACE (State or Foreign Country)		
2. 3 should	OR	9a. FACILITY NAME (If not institution, give street and number) 7118 Ocean Pines 9b. CITY, TOWN OR LOCATION OF DEATH Berlin 9c. COUNTY OF DEATH Worcester											
qui'	<u>[</u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CIT	y, TOWN C	D LOCAT	ION						
permit. Pages	L DIRECTOR	MD Worce	ester	100.01		erlir	1				10d. INSIDE CITY LIMITS? 1 YES 27 NO		
ISi	FUNERAL	7118 Ocean Pines				101.	ZIP CODE 218			10g. CITIZE	USA		
21215-0020 al or attending physician. for use as the burial-transit	ΒY	1 Never Married 2 X Merried	I.S. ARMED 2 X NO ES	1 1	f yes, spe	ENDENT OF ecify Cuban 2 X NO	i, Maxican, P	ORIGIN? (Specify Yes uerto Rican, atc.)	or No 14	A. RACE — American Indian, Black, White, atc. Specify: white			
r attending use as the	TED	15. DECEDENT'S EDUCATION (Specify only highest grade complete)		6a. DECEDENT'S (Give kind of	vork done o	CUPATIO	N st of working	7	16b. KIND OF BUSINESS/INDUSTRY				
	LET	Elementary/Secondary (0-12) Coll	IIIe. Do NOT us	itres				Resta	urant				
AND the hospital detached to	COMP	17. FATHER'S NAME (First, Middle, Last)		Wa	itres	5	16 MOTH	EO'S NAME	First, Middle, Malden				
Z & Z W	Ü	Roland James Taylo						Carey	Sumame)				
MAR e retained 5 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print) Charles T. Smith,					nd Number o	or Rural Route	Number, City or Town				
IMORE, Page 6 may be director, page		20a. METHOD OF DISPOSITION 1 [XBurlal 2 Cremation 3 Removal from State Campetery, crematory or other place) Campetery, crematory or other place) Evergreen Cemetery 3/1/95 Berlin, MD											
SALT r death. I e funeral al. examin		22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 21811											
be executed within 2. Surs cian and completely filled in 1 for to burial, cremation, or re raumatic event, the med	ATION	23. PART I. Enter the diseases, or complete abook, or heert feliure. List of immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	ONSEQUENCE OF					a cerdiac or respi	ratory arres	Approximate interval Between Onset and Death		
certificat ding phy tygiene p	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF):											
RECORDS requires that the been signed by the s. of Health and M shows any injection.	MEDICAL	PART II. Other significent conditions con	stributing to death but	not resulting	n the un	derlying	ceuse gi	iven in Par	24a. WAS AN / PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
I I AL N: The law icate has State Oep item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:				ACE OF DE	ATH (Check o	only one)				
CIAN:	YSi	1 X YES 2 □ NO 1 □	Inpetient 2 ER/Outpetic	ent 3 🗆 DOA	OTHER 4 Num		5 KRes	ildence 8 🗆	Other (Specify)				
ON OF VITA DING PHYSICIAN: The After this certificate h death with the State of marked, or item	ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF URY M	26c. INJU WOI 1 Y			d. DESCRIBE HOW IN	JURY OCCU	RED		
TTENDI TTOR: A after di	ETED I	3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, tact building, etc. (Specify)						260	City or Town, State)	nd Number or	Rural Route Number,		
7 7 7	립	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On											
TO THE HOSPITA TO THE FUNERA DE filed within 7 IMPORTANT: I	BE		with, M.	S.			29c. LICEN	NSE NUMBER		29d. DATE S	GIGNED (Month, Day, Year)		
		30. NAME AND ADDRESS OF PERSON WHO COM DO ROTTHY . HOLD	PLETED CAUSE OF DEATH	H (ITEM 27) (Type,	Print)	NOW	57		SNOW ALL	4 M	28-95 la 21865		
	مح	FEB 28 1995	32. REGISTRAR'S SIGNATU	JRE									

FOR 1 - STATE REGISTRAR

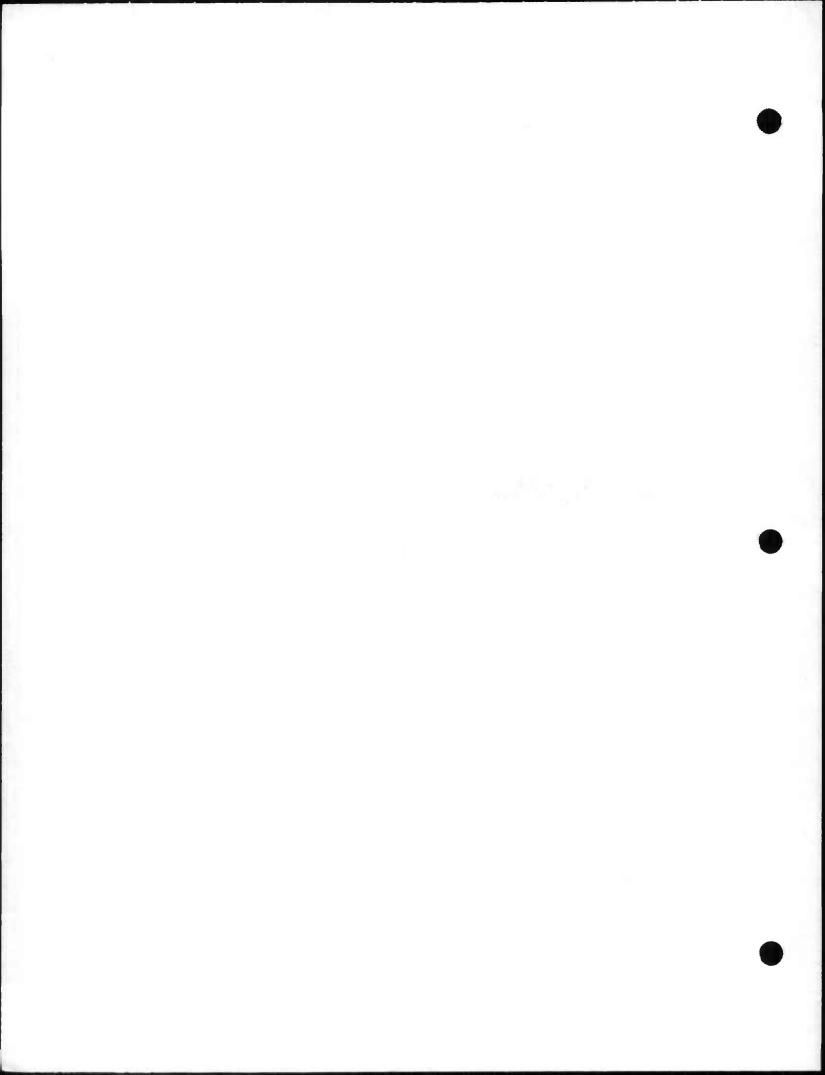
	,	REGISTRAN			ENTIFF	CAIL	PUEAIR	REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. TIME OF DEATH	
		Jean Smith S	ummerlin					Feburary	27/9	95 0320	м
		4. SOCIAL SECURITY NUMBER	5. SEX 6	AGE (In yrs. I		IF UNDER 1 YEA		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign	
		577-24-1730	1 🗆 M 2 💢 F	74	YRS.	ONTHS DAY	B HOURS MIN,	Jan 7, 19	21	Maryland	
		9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOW	N OR LOCATION OF D			TY OF DEATH	
	S S	Washington Count	v Hoenita	1		Hage	erstown		Was	hington	
	5	Washington Count									_
	DIRECTOR	10e. STATE 10b. COUNTY				TOWN OR LO				10d. INSIDE CITY LIMITS?	
			hington		Hagerstown				1 - YES 2 1 NO		
	ĭ ₹	10e. STREET AND NUMBER	9				101, ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?	
	FUNERAL	19107 Bonnie Br	iar Lane				21742-282	.2	US	A	
	크	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1	VER IN U.S. A	RMED	13. WAS (DECENDENT OF HISPA specify Cuban, Mexico	NIC ORIGIN? (Specify Yes	or No-	14. RACE — American Indian, Black, White, etc.	
	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR		,		ES 2 NO Specif			Specify:	
										White	
	COMPLETED	15, DECEDENT'S EDUC (Specify only highest grade			Give kind of wo	rk done durina	ATION most of working	16b. KIND OF BUS	INESS/INDU	JSTRY	
	凒	Elementary/Secondary (0-12)	College (1-4 or 5+)	"	le. Do NOT use			1	_		
69	N N	17. FATHER'S NAME (First, Middle, Last)	3		homen	aker		hom			
9		Charles Reginal	d Smith			Gladys	ME (First, Middle, Melden Elizabet		omont		
po s	B	19a. INFORMANT'S NAME (Type/Print)							ement		
or removal. medical examiner must be notified at once.	임	Matthew O. Summe	rlin	,	96. MAJLING A 1 Q1 \(\) 7	Roppi	et and Number or Rural e Briar La	Aoute Number, City or Town		Maryland 21742-28	02
be 7		20a. METHOD OF DISPOSITION	TILL	T				9			544
net		1 - Buriel 2 X Cremetion 3 - Remo	oval from State	cemetery, cr	AND DATE OF TEMPLE OF OTHER PROPERTY OF THE	DISPOSITION or place)	(Name of			ity or Town, State	
D 10		4 Donation 5 Other (Specify)	ENCEE -	Sintt	nsburg	-			thsbu	rg, Maryland	
E		Gerald N. Minnich 305 N. Potomac Street									
exa		Clerk 0 1,11.	mmic	X			eral Home			wn, Maryland	
removal		23. PART I. Entar the diseases, or c	omplications that c	aused tha d	eath. Do no	t anter tha	moda of dying, auc	h aa cardiac or reapi	retory arre	st, Approximata	
		shock, or heart failure. I				L.		_		Interval Betwee	
the the		disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Onaet and Death Onaet and Death									
event, the		resulting in death)	DUE 10 (0)	AS A CONSE	OUENCE OF):	/dc 0 =	0	- 0			\dashv
atic e	z	<u> </u>								_ [
SE	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury Cerebrovascular accidents)									
		cause. Enter UNDERLYING CAUSE (Disease or Injury	. Cer	cbrow	ascula	v accie	lent				
or other	ERTIFI	that initiated events	DUE TO (OI	AS A CONSE	OUENCE OF):						
6 F	E	resulting in death) LAST d. hyper calcernia									
and Mental	Ö	PART II. Other algnificant conditions	a contributing to de	ath but not	ranultina la	the renderly	des sous store to	B-21 2			
and in	DICAL	End Stage y			reauting in	ure underly	ing cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	3
saith an	Ē				1 2:5.	100	.0	1 _ YES 2	NO	OF DEATH?	
P NO	Σ	Status post sigmo	nd CHecton	my will	seym	ora coc	offerny	_ 1		1 🗌 YES 2 🔁 NO	
	AN:	DID TOBACCO USE CONTR	RIBUTE TO CAUS					1			_
23 ep	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26, PLA	CE OF DEATH	(Check only or	70)				\exists
ate Dept.	YSI	1 TYES 2 NO	1 ⊠npatient 2 □ E	R/Outpatient			ome 5 🗆 Residence	a □ Other (Specify)			
he State Dept. or item 23	РНУ	27. MANNER OF DEATH	28s. DATE OF IN. (Month, Day,		28b. TIME		INJURY AT WORK?	26d. DEŞCRIBE HOW IN	JURY OCCU	JRED	П
6 g		1 M Natural S D Bandler				M 1 [YES 2 NO				- 1
with the	>	1 Netural 5 Pending 2 Accident Investigation					28t. LOCATION (Street and Number or Rural Route Number.				
with with	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF II building, atc	JURY — At h	ome, farm, atr	eet, tactory, o	Hica	28t. LOCATION (Street a City or Town, State)	nd Number o	r Rural Route Number,	\exists
after death with the 28 is marked, or	TED BY	2 Accident Investigation	28e. PLACE OF II building, atc	JURY — At h . (Specify)	ome, farm, atr	et, factory, o	ffice		nd Number o	r Rural Route Number,	
after death with the 28 is marked, or	TED BY	2 Accident 3 Suitctde 4 Homicide 29a. CERTIFIER (Check only) 2 CERTIFYING PHYSK	building, atc	. (Specify)				City or Town, State)			
after death with the 28 is marked, or	MPLETED BY	2 Accident 3 Suitcide 4 Homicide 29a. CERTIFIER (Check only) 2 CERTIFYING PHYSK	CIAN: To the best of my	knowledge, d	eath occurred	at the time, d	ete and place, and due	City or Town, State) to the cause(s) and men	ner aa stated		
after death with the 28 is marked, or	COMPLETED BY	2 Accident 3 Suitcide 4 Homicide 29a. CERTIFIER (Check only) 2 CERTIFYING PHYSK	CIAN: To the best of my	knowledge, d	eath occurred	at the time, d	ete and place, and due	City or Town, State) to the cause(s) and men time, data and place, and	ner as stated	i. cause(a) and manner se stated.	
filed within 72 hours after death with the IPORTANT: If Item 28 is marked, or	BE COMPLETED BY	2 Accident 3 Sutcide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	CIAN: To the best of my	knowledge, d	eath occurred investigation,	at the time, d	ate and place, and due t, death occured at the 29c. LICENSE NUR	City or Town, State) to the cause(s) and men time, data and place, and	ner as stated due to the 29d, DATE	1.	
within 72 hours after death with the TANT: If item 28 is marked, or	E COMPLETED BY	2 Accident 3 Sutetide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	CIAN: To the best of my	knowledge, d	eath occurred investigation,	at the time, d	ate and place, and due t, death occured at the 29c. LICENSE NUR	City or Town, State) to the cause(s) and men time, data and place, and	ner as stated due to the 29d, DATE	i. cause(a) and manner se stated.	
filed within 72 hours after death with the IPORTANT: If Item 28 is marked, or	BE COMPLETED BY	2 Accident 3 Suitcide 4 Hornicide 29a. CERTIFIER (Check only 0ne) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my	knowledge, d	eath occurred investigation,	at the time, d	ate and place, and due t, death occured at the 29c. LICENSE NUR	City or Town, State) to the cause(s) and men time, data and place, and	ner as stated due to the 29d, DATE	f. cause(a) and manner se stated.	
filed within 72 hours after death with the IPORTANT: If Item 28 is marked, or	TO BE COMPLETED BY	2 Accident 3 Sutcide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO P BAY UR AO, MI	CIAN: To the best of my	knowledge, delination and/or	eath occurred investigation,	at the time, d	ate and place, and due t, death occured at the 29c. LICENSE NUR	City or Town, State) to the cause(s) and men time, data and place, and	ner as stated due to the 29d, DATE	f. cause(a) and manner se stated.	

BALTIMORE, MARYLAND 21215-0020

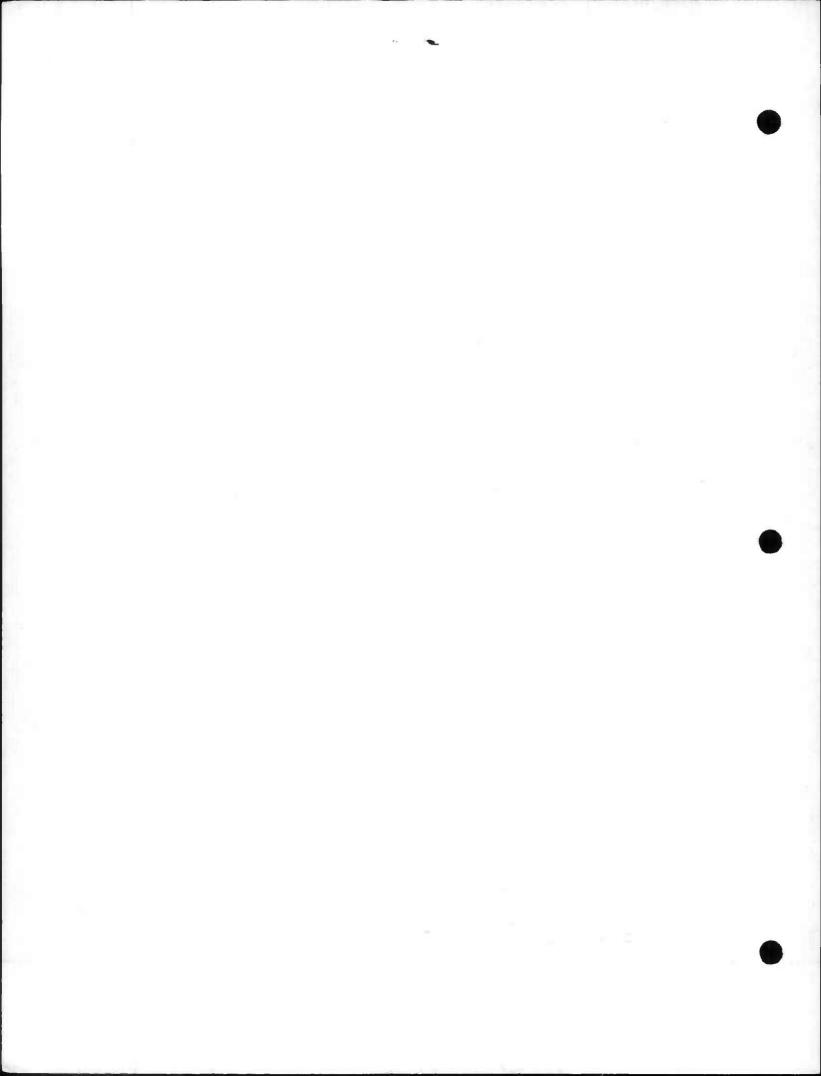
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	PORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR AI	TO THE FUNERAL DIRECT DIRECT DIRECT TO THE FILED WITHIN 72 HOURS	IMPORTANT: If Item :	

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF	HEALTH AND M	REG. NO.								
	1. DECEDENT'S NAME (First, Middle, I	Lest)				2. DATE OF DEATH	3. TIME OF DEATH /							
	Thelma Katheri	ne SEATON				February	201995 1200 M							
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BURTH	A BIRTHRI ACE (State or Coming							
	214-16-1919		76 YRS.	MONTHS DAYS	HOURS MIN.	June 23,191	.8 Maryland							
œ	9a. FACILITY NAME (II not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Washington County Hospital Hagerstown Washington													
DIRECTOR	Washington Cou				lagerstown	1	Washington							
350	10e. STATE 10b. CO		10c, CITY	, TOWN OR LOC	TION		10d. INSIDE CITY							
		ashington		Hagerst	own		1 XYES 2 NO							
3AL	10e. STREET AND NUMBER				of. ZIP CODE	1	0g. CITIZEN OF WHAT COUNTRY?							
FUNERAL	750 Dual Highw				21740		USA							
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 XNO		CENDENT OF HISPANIC pecify Cuben, Maxican,	ORIGIN? (Specify Yes or Puerto Ricen, etc.)	No- 14. RACE — American Indian, Black, White, atc.							
B	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 🗆 YE	S 2 🔀 NO Specify:		Specify: White							
G	15. DECEOENT'S (Specify only highest	EDUCATION	18a. DECEDENT'S	USUAL OCCUPAT	ON	16b. KIND OF BUSING								
ᄪ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	rork done during m e retired.)	ost of working									
COMPLETED	8	0	housev	wife		her own								
႘	17. FATHER'S NAME (First, Middle, Last					E (First, Middle, Maiden Sur								
H H	Chalmers S. 19a. INFORMANT'S NAME (Type/Print)	Gordon				h Hornbake								
요	Jane L. Myer	· c			end Number or Rural Ro r Drive	ute Number, City or Town, S	inere, Zip Coole) 1, Maryland 21740							
	20s. METHOD OF DISPOSITION	20	b. PLACE AND DATE O				ION - City or Town, State							
	1 Buriel 2 □ Cremation 3 □ Donation 8 □ Other (Specify)	Removal from State	metery, cremetory or other Rest Have	her plece)	erv 2-23									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740													
	23. PART I. Enter the diseases,	or complications that cause	d tha daeth. Do n	ot antar tha m	oda of dying, auch	as cardiac or respirate	ory arrest, Approximata							
	anock, or heart falls	ura. List only ona cause on	ach ilna.				Intarval Batween							
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death													
	ACCOUNT VALUE			,.		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DISTANT BYCAS							
S	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
CALION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF):										
	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS	A CONSEQUENCE OF):										
HIL	reaulting in death) LAST	d												
3	PART II. Other algnificant cond	tions contribution to death	aut not ensulting in	a the content of										
3	<u> </u>	N4	ar nor resulting ii	ii the ungariyir	g cause givan in P	PERFORME								
					-	_ 1 TYES 2	NO OF DEATH?							
PHYSICIAN: MEDIC	DID TOBACCO USE CO	NTRIBUTE TO CAUSE O	DE DEATH YE	S NO [UNCERTAIN		1 TES 7 NO							
A P	25. WAS CASE REFERRED TO MEDICA	AL .	28. PLACE OF OEAT											
2	1 YES 2 HO	HOSPITAL:		OTHER:	ne 5 🗆 Rasidenca 6	Other (Specify)								
E	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Dgy, Year)	28b. TIME	OF 28c. IN		28d. DESCRIBE HOW INJU	RY OCCUREO							
2	1 Natural 5 Pending Investigation	lon N/A	NI	4 1 1 0	YES 2 NO	N	IA							
	3 Culoldo	be 28a. PLACE OF INJUR	/ — At home, farm, st city)	treet, factory, offi	a :	281. LOCATION (Street and City or Town, State)	Number or Rural Route Number,							
	3 Suicide 8 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
	4 Homicide detarmine	N/	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.											
	4 Homicide detarmine 29a. CERTIFIER (Check only	HYSICIAN: To the best of my know												
	29a. CERTIFIER (Check only one) 2 MEDICAL EXAM	HYSICIAN: To the best of my know					as stated,							
BE COMPLETED	4 Homicide detarmine 29a. CERTIFIER (Check only	HYSICIAN: To the best of my know				ne, data and place, and du								
BE COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAL	HYSICIAN: To the best of my know	n and/or investigation	n, in my opinion,	leath occured at the tir	ne, data and place, and du	us to the cause(s) and menner as stated.							
10 BE COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAL	HYSICIAN: To the best of my know	en and/or investigation	n, in my opinion,	29c. LICENSE NUMB	Ter 365	us to the cause(s) and menner as stated. Id. DATE SIGNEO (Month, Day, Year) 2/20/95							
BE COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAL	HYSICIAN: To the best of my know	en and/or investigation ATH (ITEM 27) (Type. A PUB!	n, in my opinion,	29c. LICENSE NUMB	ne, data and place, and du	us to the cause(s) and menner as stated. Id. DATE SIGNEO (Month, Day, Year) 2/20/95							



	1. DECEDENT'S NAME (First, Mi	iddie, Last)				-			2. DATE	E OF DEATH	AY	YEAR	3. TIME OF DEATH
	Kazuko	H	ukuchi			Stearns	3			ruary			1:09 A.M
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In	yrs. last birthda				7. DATE	OF BIRTH th, Day, Year)		B. BIRTH Count	HPLACE (State or Foreign
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	9a. FACILITY NAME (If not institu	ution, give stre	et and number)			96. CITY, TO	WN O	R LOCATION OF DE				DEATH	
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	Earl E. Stearns 1756 Brookside Drive Edgewood , Md. 2104												
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	21. SIGNATURE OF FUNERAL S		NSEE	re	erris o		AE AN	ID ADDRESS OF FA		-93 W.	Ches	ter	ra.
	Howard K. McComas III Funeral Ho									ome P.A.			
	1317 Cokesbury Rd. Abingdon,									Mc	1 21000		
	23. PART I. Enfer the disasses, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.												1. 21007
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending ph	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bu	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	the manufacture of the second

		FOR 1 STATE	STATE OF MARY	YLAND / DEPAI	RTMENT O	F HEALTH AND	MENTAL HYGIE	NE	
	_	REGISTRAR		CERTIF	ICATE (OF DEATH	REG. N	D.	
		1. DECEDENT'S NAME (First, Middle, Last) John	Holly Sa	nford J	r.	F	2. DATE OF DEATH WONTH e Druary	DAY 2 3	3. TIME OF DEATH 1 95 11:41 P.
		4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)		EAR IF UNDER 24 HRS.	7 DATE OF BIRTH		S. BIRTHPLACE (State or Foreign
		579-16-5664 9e. FACILITY NAME (If not institution, give str	1 💢 M 2 🗆 F	, ,			May 30,	7	Washington DC
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	A	10e. STREET AND NUMBER				101. ZIP CODE		10g. CIT	IZEN OF WHAT COUNTRY?
	FUNERAL	9875 The Sanford	Place			20664		Uni	ted States
	5	11. MARITAL STATUS	12. WAS DECEDENT EVE		13. WAS	DECENDENT OF HISPAN	HC ORIGIN? (Specify Y		14. RACE — American Indian, Black, White, etc.
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	BE	19e. INFORMANT'S NAME (Type/Print)	πα				Dennison		
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anst.		20a, METHOD OF DISPOSITION XX Burlel 2 Cremetion 3 Remo 4 Donetion 8 Other (Specify)	wal from State	cemetery, crematory or o	other place)	N(Neme oFeb 27	' L		
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edic		23. PART Enter the diseases, or constant shock, or heart fallure. L	omplications that cau- ist only one cause or	asd the desth. Do	not enter the	mods of dying, suc	h as cardisc or rea	piratory ar	rest, Approximata
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FUNERAL DIRECTOR: After this certificate has been within 72 hours after death with the State Dept. of

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENOING PHYSICIAN: The la
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Helen Dorothy Smith Feb 22,1995 6:45P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign (Month, Day, Ye. 579-32-1730 HOURS 1 M 2 🔀 75 DAYS YRS. Dec 29,1919 Washington DC 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 14609 Brandywine Heights Road Prince George's Brandywine RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Brandywine Maryland Prince Georg'es 1 TYES 2 X NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 14609 Brandywine Heights Road United States 20613 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MADITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Maxican, Puarto Rican, atc.)

 YES 2 NO Specify: 14. RACE - American Indian, Black White etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Retail Accounts Receivable 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Harry notified at BE Bernard Bolac 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 20 Sherman Street, Gonic, New Hampshire, 03839 Jesse Robert Smith ě 20a METHOD OF DISPOSITION

1 X Burtal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of March 1, 1995) 20c. LOCATION - City or Town, Sieta must Arlington National Cem Arlington , Virginia 4 Donation 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY OF FUNETAL HOME, INC 6633 Old Alexander Ferry Road, Clinton, Md 20735 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ehock, of heert feilure. List only one ceuse on each line. Approximete intervsi Between IMMEDIATE CAUSE (Final Onset and Death the diseese or condition resulting in death) traumatic event, Carcin CERTIFICATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other QUE TO (OR AS A CONSEQUENCE OF)that initiated events resuiting in deeth) LAST 6 PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL amy COMPLETION OF CAUSE 1 | YES 2 | NO Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 1 TYES 2 NO YES □ NO □ UNCERTAIN □ PHYSICIAN: 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA **EXAMINER?** OTHER: 1 YES 2 NO ng Home 5 - Rasidenca 6 - Other (Specify) 0 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 26d. DESCRIBE NOW INJURY OCCUREO 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify) 60 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 6 Could not be 4 Homicide 280 COMPLET tem 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the Ilme, data and place, and due to the cause(s) and manner as steted. 32 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) and menner ea stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MID 9 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print)

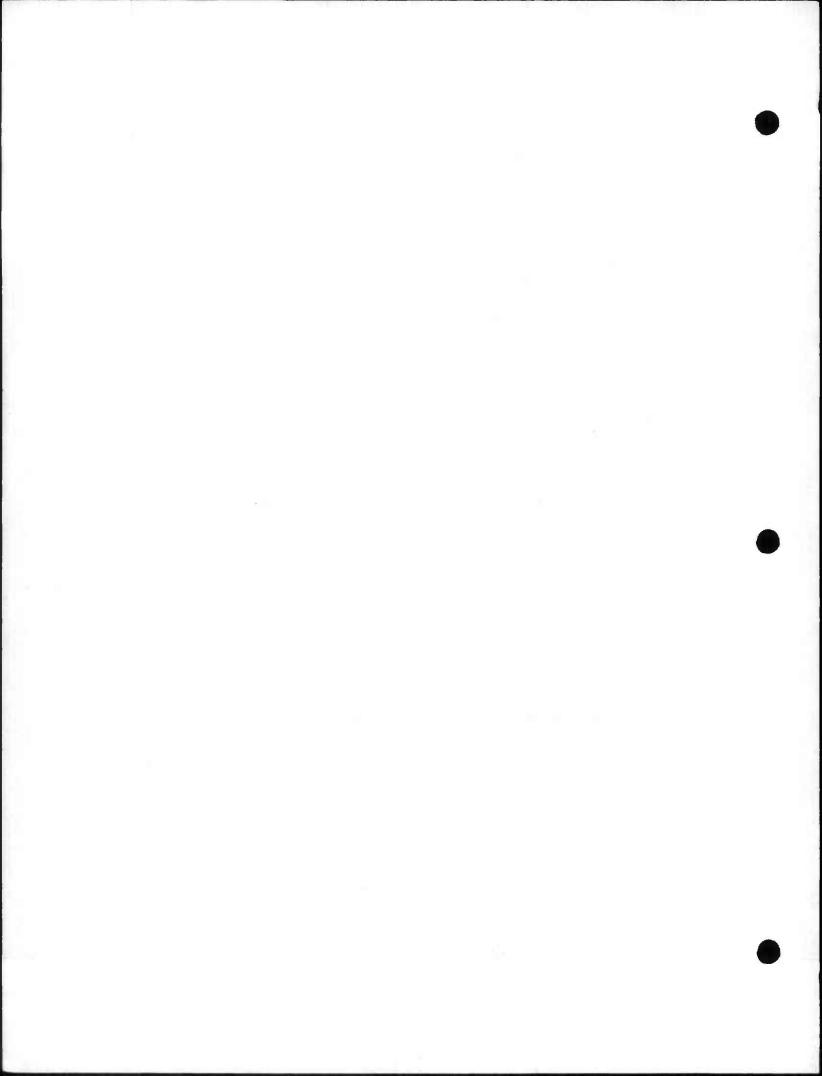
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32. REGISTRAR'S SIGNATURE RANGELL

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1. DECEDENT'S NAME (First									2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH
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- 1	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.	(ast birthday)	IF UNDER	DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Your)		Countr	
	213-78-7477 9a. FACILITY NAME (# not ir		4.5	69	THO.	05.007	, TOMAL			May 28,	_		land
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Ä	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY LIMITS?
	Maryland	Cecil	·		Elkton							1 YES 2 X NO	
¥	10e. STREET AND NUMBER							. ZIP CDD			10g. Cl	TIZEN OF W	HAT COUNTRY?
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<u> </u>	11. MARITAL STATUS		12. WAS DECEDENT			13.	WAS DEC	ENOENT C	OF HISPAN	IC ORIGIN? (Specify 'n, Puarto Rican, etc.)	ea or No-	14. RACE	— American Indian, , White, etc.
<u>A</u>	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W		44.00			2 X NO					White
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COMPLETED	Elementary/Secondary (6	1-12)	College (1-4 or 5+	,	Iomema								
8	17. FATHER'S NAME (First, Middle, Lest) James Goodwin Jackson 18. MOTHER'S NAME (First, Middle, Meiden Surname) Mahle Norris												
	Jam						Mable No	,					
8	19a. INFORMANT'S NAME (Type/Print)								Route Number, City or 1			
임	Linda K. S	weet			11 Jo	seph	Gal	lahe	r St	reet - El	kton,	, MD	21921
	20a. METHOD OF DISPOSIT		val from State	20b. PLA	E AND DATE	OF DISPOS	SITION (No	ime of		/-/		- City or To	
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ł	21. SIGNATURE OF FUNERA	L SERVICE LICI	ENSEE			22. H	NAME AL	HOM-	ss of face	r Funeral	s, P.	Α.	
	Dan 4	1.4	0 11.	هما		10	03 W	est	Stoc	kton Stre	et		
	23. PART I. Enter the d	iseases, or co	omplications that	caused the	death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approx							Approximate	
	snock, or h		let only one cau	sa on each i	lne.		*lan-						Interval Between Onset and Death
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CERTIFICATION	that initiated events resulting in death) LAS	т	302 101	(ON AS A CON.	SEDUENCE O	т. у.						•	•
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	PART II. Other aignifica	onditions	contributing to	death but no	t resulting	in the ur	nderlyin	g ceuse	given in		N AUTOPSY	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL									1 _ YES	COMPLETION DF CAUSE OF DEATH?			
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등	25. WAS CASE REFERRED T EXAMINER?		HOSPITAL:			OTHE		ACE OF 0	EATH (Che	ock only one)			
PHYSICIAN: M	1 TES 2 NO		1 Inpatient 2		3 DOA			10 5 X Ri	sidence	6 Other (Specify)			
ᇤ	27. MANNER OF DEATH	Pending	28a. OATE DF (Month, De		26b. TIN	JURY		URY AT		28d. DESCRIBE HDV	INJURY O	CCURED	
≽∥	2 Accident	Investigation				М		YES 2	NO				
		Could not be determined	28e. PLACE Of building,	F INJURY — At atc. (Specify)	home, ferm,	street, fect	lory, offic	•		28t. LOCATION (Stree City or Town, Sta	t and Numb te)	er or Rural R	loute Number,
<u>.</u>													
COMPLETED	(Check only									to the cause(s) and n			
8	2 MEO	ICAL EXAMINER	t: On the beels of ax	amination and	or investigation	on, in my o	opinion, d	leath occur	red at the	time, date end place,	and dua to	the cause(s) and menner as stated.
B	296. SIGNATURE AND TITLE	OF CERTIFIER		1/	()	/		29c. LICI	ENSE NUN	IBER	29d, DA	TE SIGNED	(Month, Day Year)
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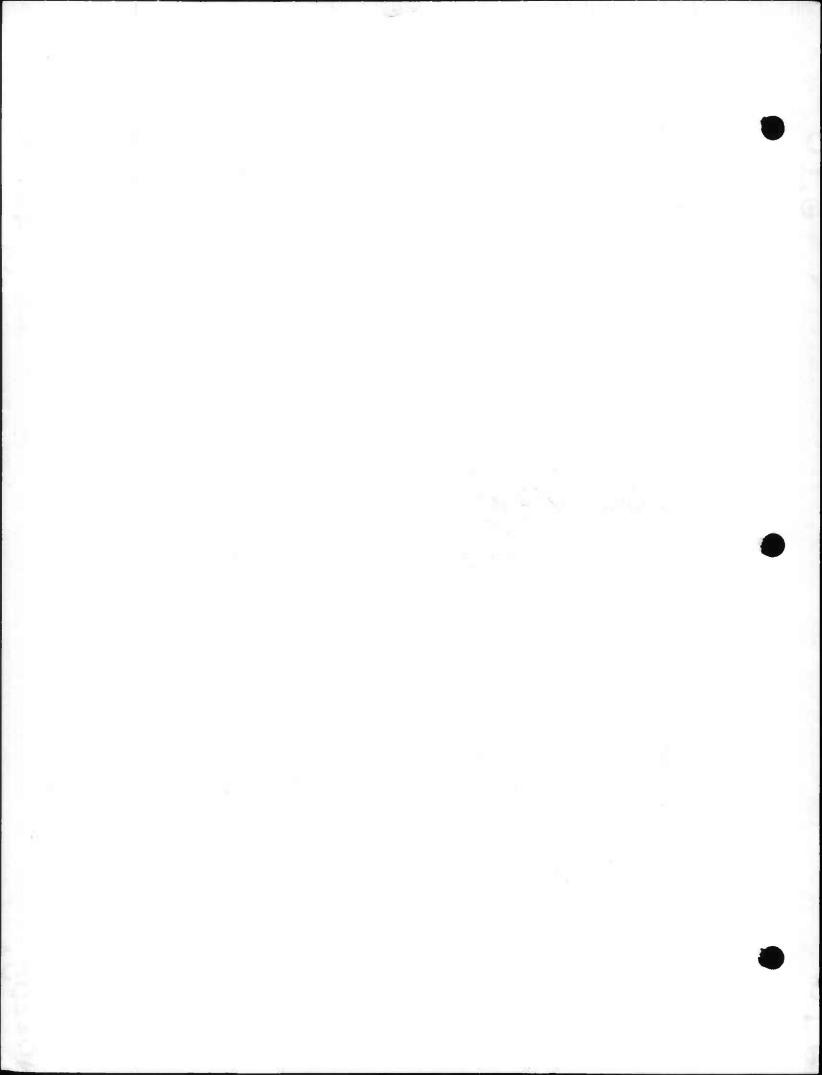
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 1200P 11 E SULT (Mary Ellen Suit) 7. DATE OF BIRTH (Month, Day, Ye 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR 215-14-5360 DAYS HOURS 1 🗌 M 2 😿 F 75 YRS. 01/1919 Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Anne Arundel Medical Center Annapo Li s DIRECTOR Anne Arundel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Annapolis XXYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 311 North Glen Avenue 21401 United States after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, atc.)

1 YES 2 Specify. 11. MARITAL STATUS 14. RACE - American Indian, Black, White, atc. FORCES? 1 YES 2 Never Merried 2 Merried ВУ 3 Widowed 4 Divorced White ED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) E Elementary/Secondary (0-12) College (1-4 or 5 +) funeral director, page 5 should be detached for COMPL 12 State of Maryland Clerk once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Sumerne) 65 Edith T. Howes Albert B. Suit BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret I. Suit 311 North Glen Avenue Annapolis, MD 21401 209. METHOD OF DISPOSITION 9 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE musi St. Mary s Cemetery 2/28/95 Annapolis, Maryland 4 Donetion 5 Other (Specific examinar 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by shock, or heart failure. List only one cause on each line. Interval Between ō Onset and Death IMMEDIATE CAUSE (Final HODGKIND LYMPHUMA 94 cremation, disease or condition Now completely resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): and com traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): ...uning physician a If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST 0 the atten any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL Health and I AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 OF DEATH? Shows 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 8 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem the State HOSPITAL: OTHER 1 YES THO 1.2 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 28e. DATE OF INJURY (Month, Day, Year) 27 MANNER OF DEATH 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 1 YES 2 NO After the death v BY Investigation 2 Accident ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 109 3 Suicide 6 Could not be COMPLETED DIRECTOR: hours after 4 Homicide 28 Hem OR 29e. CERTIFIER K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated FUNERAL Within 72 I = 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 HATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Udlum PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 25 9 ATILINS 500 BUNDANIS mo STANLET BESTOATE RD 31. DATE FILEO (Month, Day, Year) FEB 28 1995 32. REGISTRAD'S SIGNATURE

DHMH-16 Rev 1/89

		REGISTRAR		DEPARTMENT OF RTIFICATE O		IENTAL HYGIENE REG. NO.		
	į,	1. DECEDENT'S NAME (First, Middle, Last)	50	linnens	,	2. DATE OF DEATH DAY	YEAR	3. TIME OF DEATH
_		4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. last			7. DATE OF BIRTH (Mynth) Day, Year)		IPLACE (State or Foreign
Pin		220-84-6770 1		YRS. MONTHS DAYS		4/29/	62 Mai	ryland
1, 2, 3 should	DIRECTOR	ANNE Armudel	Gen Ho	Sp An	OR LOCATION OF DE	(13	He. COUNTY OF D	EATH
permit. Pages		Mary I and Anne Arund	el	Annapoli	S			10d. INSIDE CITY LIMITS? 1 YES Z NO
15	FUNERAL	32 Oak Court			21401		United	
21215-0020 or attending physician. or use as the burial-transit	В	1 Never Married 2 X Married FORCES	CEDENT EVER IN U.S. ARM 7 1 1 YES 2 NO. GIVE WAR OR DATES	O If yes,	ECENDENT OF HISPANI specify Cuban, Mexican ES 2 NO Specify:	C ORIGIN? (Specify Yes o , Puerto Rican, etc.)	Black	E — American Indian, k, White, etc. ^{Illy:} White
21215 al or attend for use as	TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(GM	EDENT'S USUAL OCCUPA re kind of work done during a Do NOT use retired.)	TION most of working	16b. KIND OF BUSIN	IESS/INDUSTRY	
2 2	TO BE COMPLETE	Elementary/Secondary (0-12) College (1-4	or 5+)	Produce		GR	OŒRY/FO	∞
MARYLAND 212- retained by the hospital or att 5 should be detached for use notified at once.		17. FATHER'S NAME (First, Middle, Last) Gordon Harpe	r			E (First, Middle, Meiden St. rgia Norfo		
MARY retained by 5 should to		19a, INFORMANT'S NAME (Type/Print)		MAILING ADDRESS (Stree				
E, M y be ret page 5 s		Francis A. Seligman		32 Oak Court		is, Md. 21	401	
BALTIMORE, ter death. Page 6 may be the funeral director, page oval.		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify)	te cemetery, crem	ND DATE OF DISPOSITION (natory or other place) LINCOLN Cren			ATION City or To	
ALTIN death. Pag e funeral dir al. examiner		21. SIGNATURE OF FUNGRAL SERVICE LICENSEE	1	22. NAME	AND ADDRESS OF FAC			ALC: NO STATE OF
BALTIMORE, after death. Page 6 may be noval. cel examiner must be		Muyne 19 Jugs	ly_	lof G	oucester	Funeral Hor St., Annapo	olic MA	147 Duke
in 24 rours ely filled in thation, or ref		23. PART I. Enter the diseases, or complication shock, or heart failure. List only on iMMEDIATE CAUSE (Final disease or condition resulting in death)	Cause on each line.	UENCE OF:			tory arrest,	Approximate interval Between Onset and Death
		T	1					
. 4 8 " o E	ATION	Sequentially fist conditions, if any, leading to immediate cause. Enter UNDERLYING	EPVESS JE TOUGH AS A CONSEQU					
P.O. B n certificat ending phy Hygiene p or other	CERTIFICATION	CAUSE (Disease or injury	JE TO (OR AS A CONSEQU	UENCE OF):				
DS, F the death the atter d Mental injury, o	AL C	PART II. Other aignificant conditions contribution	ng to death but not re	aulting in the underlyi	ng cause given in F			. WERE AUTOPSY FINDINGS
RECOR requires that been signed by of Health an shows eny	MEDIC					PERFORM 1 YES 2		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
F 2 2 5	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			PLACE OF DEATH (Chec	ck only one)		
CIAN:	HYSI	1 VES 2 NO 1 Inpatien	TE OF INJURY		me 5 Residence 6	Other (Specify) 28d. DESCRIBE HOW INJ	HIP OOMINED	
	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	22/95	INJURY V	YES 2 NO	Took	DUCI	dose
TTEN TOR: after	ETED	3 Suicide 28e. PL	ACE OF INJURY — At hom Iding, etc. (Specify)	one, farm, street, factory, off	lics	281. LOCATION (Street and City or Yown, State)	Number or Rural F	mod -
E BE	COMPLI	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the E) and menner as stated.
TO THE HOSPI TO THE FUNER be filed within	TO BE C	296 BIGNATURE AND TITLE OF CERTIFIER	i com	Deputy	29c. LICENSE NUMI	DER 2054	Pad. DATE SIGNED	(Month, Day Year) 3 45
	-	30. HAME AND ADDRESS OF PERSON VEND COMPLETE	cause of Death (ITEM		75 K	Imeric	· A 2	1035
		31. DATE FILED (Month, Day, Year) 32. REG	STRAR'S SIGNATURE	dell				



DAL IMURE, MARTLANI	ours after death. Page 6 may be retained by the hos	I in by the funeral director, page 5 should be detached removal.	nedical examiner must be notified at once.
CHARLES OF VITAL RECORDS, T.O. BOX 88/80	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detactive be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND / CE	DEPARTM	ENT OF H	IEALTH AND	MENTAL	HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH	<u> </u>		3. TIME OF DEATH	Н
	THOMAS	EDWARD	SIL	VIA			Febru	iary 23.		YEAR	4:40	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	. AGE (In yrs. lest	birthday) IF L	NDER 1 YEAR	IF UNDER 24 HRS	7. DATE	OF BIRTH	1000	s. BIRTH	IPLACE (State or For	
	216-18-2439	1 🔀 M 2 🗌 F	70	YRS. MON		HOURS MIN.	Septe	mber 17		Ma	ryland	
m	9a. FACILITY NAME (If not institution, give a	treet and number)		9b.		OR LOCATION OF	DEATH		9c. COUR			
0	402 Railway St.				Sharp	town			\ \ \	Vicor	M1CO	
EC	10s. STATE 10b. COUNT	Y		10c. CITY. TO	WN OR LOCAT	TION					10d. INSIDE CITY	
DIRECTOR	Maryland Wi	comico			ptown						LIMITS?	
FUNERAL	100. STREET AND NUMBER 402 Railway St	•			10	2 186	1		10g. CITI	USA	VHAT COUNTRY?	
<u>\$</u>	11. MARITAL STATUS	12. WAS DECEDENT			13. WAS DEC	ENDENT OF HISE	PANIC ORIGIN	? (Specify Yes	or No —	14. RACE	— American India	0
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	XYES 2 NO R OR DATES WW II	١	If yes, sp	ecify Cuban, Mex 2 X NO Spe	Ican, Puerto R			Speci	c, White, etc. fy:	.,
	15. DECEDENT'S EDU	CATION		EDENT'S USU/	1 OCCUPATION	DN .	1 404	KIND OF BUS	I I	7.7.8.8.	ite	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Gh	e kind of work of Do NOT use reti	one during mo	st of working	100.	KIND OF BU	MINESS/HAD	USTRT		
AP	12		Dept	. of N	atural	Resources	S St	tate o	f Man	yla	nd	
5	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S	NAME (First, M	liddle, Maiden	Sumame)			
BE (John Thomas	Silvia				Sarah			Hende		n	
2	190. INFORMANT'S NAME (Type/Print) Edna Silvia		19b.			7, Shar				Code)		
	20a. METHOD OF DISPOSITION		20h PLACE AL	ND DATE OF DIS			OATE		CATION (City of You	oun Ctata	
	tX Buriel 2 Cremation 3 Rem 4 Donation 8 Other (Specify)	oval from State	Sprin	netory or other pi	demory	Garden	2/2	7 He	bron	,	wn, stata	
	21. SIGNATURE OF FUNERAL SERVICE U	ENSEE /	TOPLIN	J		ID ADDRESS OF		, 116	DI OII	, III		
	»/11/2/2/	01.	1			loway F						
\vdash	23. PART i. Enter the diseases, or	an	$\gamma \nu$	7	501	Snow H	ill Ro	l., Sa	lisbu	ıry,	MD 2180	
	shock, or haart feilure.	List only one cause	on each line.	ith. Do not e	iter tha mo	de of dying, s	uch se card	lac or reapl	ratory arr	est,	Approxima interval Be	tween
	iMMEDIATE CAUSE (Final disease or condition	Ja.	lostic	Class	10.00	a-A	011	or or i			Onset and	Death
	resulting in death)	a. DUE TO (C	AS A CONSEC	UENCE OF):	nvin	0	nun	aug			Um	202
2	DUE TO (OR AS A CONSEQUENCE OF):										j	
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	c										
틸	that initiated events	DUE TO (O	R AS A CONSEQU	UENCE OF):								
8	resulting in death) LAST	d										
	PART II. Other significent condition	s contributing to d	eath but not re	eulting in the	underivin	a course obven	in Doct i	04- 1460 411	ALEMANA	411		
8		- volumbating to u		outing in the	or a real or year	a cansa Aisau	m rant i.	24s. WAS AN PERFOR	MED?	240.	MAILABLE PRIOR T	0
							- 1	1 TYES 2	NO		OF DEATH?	NUSE.
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AN	DID TOBACCO USE CONT	KIBUTE TO CAU				UNCERTA	IIN L					
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	1 Natural 5 Pending	28s. OATE OF IN (Month, Day,	Year)	28b. TIME OF INJURY		RK?	28d. DE\$6	CRIBE HOW II	NJURY OCC	URED		
BY	2 Accident Investigation	98- PI 108-5-	AL HARRY			YES 2 NO	-					
E	3 Suicide 8 Could not be 4 Homicide detarmined	building, et	INJURY — At horr c. (Specify)	ie, farm, street,	factory, offic	•	281. LOCA City o	TION (Street & v Town, State)	nd Number	or Rumi A	loute Number,	
ET	29a. CERTIFIER											
COMPL	(Check only											
Ö	2 MEDICAL EXAMINE	R: On the beals of axes	mination and/or in	vestigation, in	my opinion, d	eath occured at t	he time, date	and place, an	d due to the	cause(s) and manner as sta	rted.
-	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yea										(Month Day Year)	
m m	V . 1	01-	0 '1	0		7						
TO BE	30. NAME AND ADDRESS OF PERSON H	a. Wen		h D		D15.	384				7-95	

SALISBURY

RODNEY A. WEN

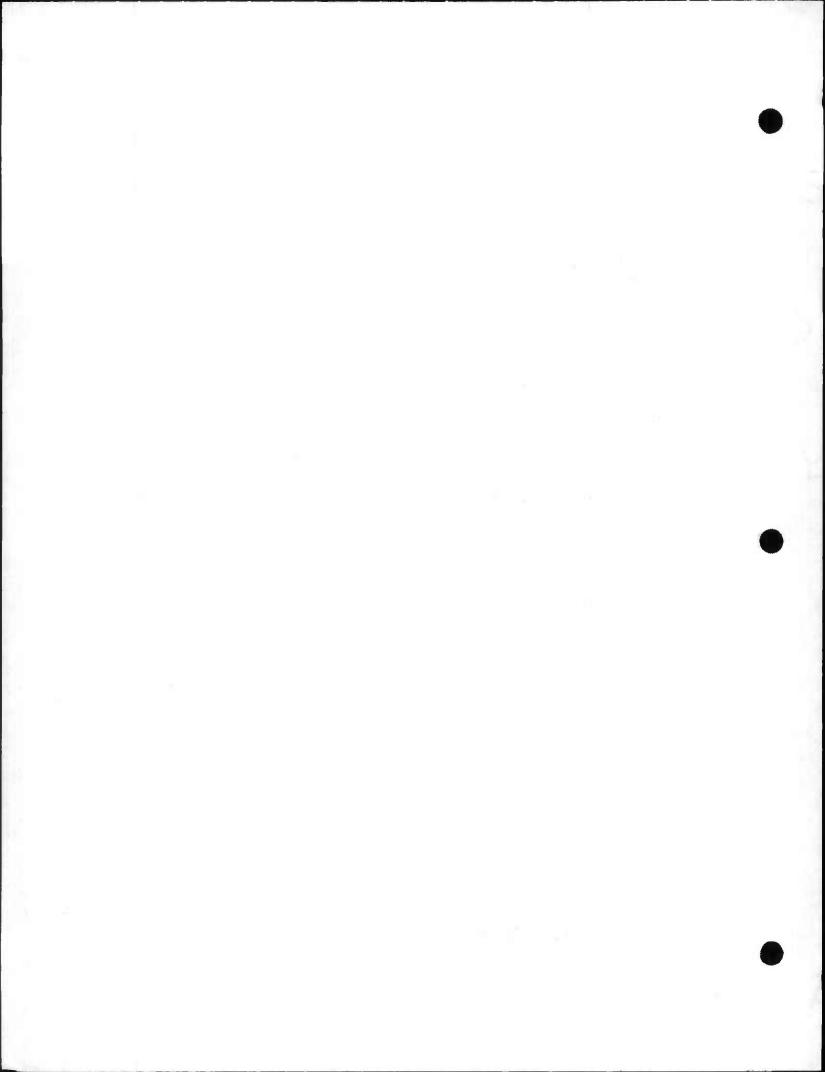
31. DATE FILED (Month Day Year)

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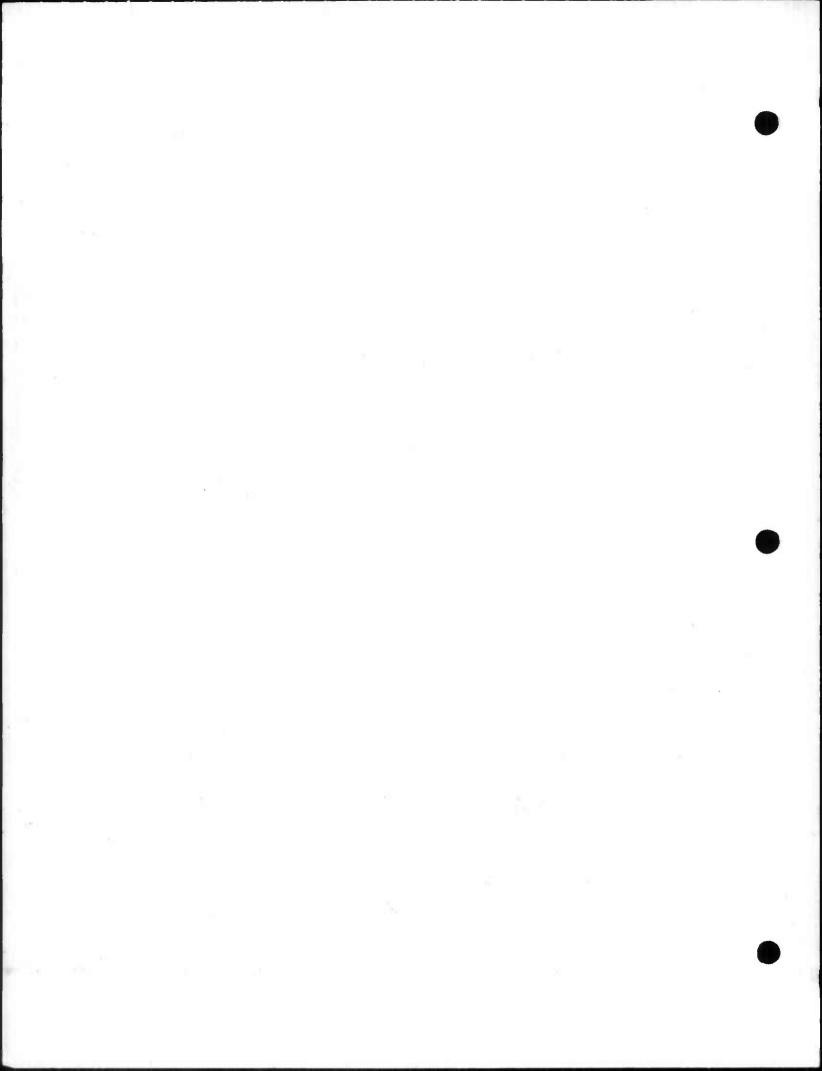
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEP	ARTMENT OF FICATE OF	HEALTH AND	MENTA	HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		3	TIME OF DEATH	-
		BESSIE K	atherine		stanl	ey	F-el	ruers		YEAR	0135	м
		4. SOCIAL SECURITY NUMBER		n yrs. lest birthde	y) IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH , Day, Year)			ACE (State or Forei	ign
2		219-07-1358	1 □ M 2 戻 F 7.	3 YRS	- DAYS	HOURS MIN.		h 19,19	21		yland	
3 should	000	9a. FACILITY NAME (If not institution, give s		EMMED		OR LOCATION OF D	EATH		9c. COUNT			
. 2. 3	DIRECTOR	PENINSULA REGION	AL MEDICAL CI	ENTER	SA.	LISBURY			MTG	COMIC	;0	
ges 1	EC.	10e. STATE 10b. COUNT	Y	10c.	TY, TOWN OR LOCA	ATION			_	10	d. INSIDE CITY	
~ ~		Maryland Wic	omico		Fruitlan	d				0	LIMITS?	0
bed	FUNERAL	10e. STREET AND NUMBER			10	Of. ZIP CODE			10g. CITIZE	N OF WH	AT COUNTRY?	
an. ransit	NE.	109 William St.				21826			U:	SA		
hysici urial-t	F	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 X NO	13. WAS DE	CENDENT OF HISPAI pecify Cuban, Maxica	NIC ORIGIN	? (Specify Yes	or No-	Black, Y	American Indian, White, etc.	
ing p	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1 🗆 YE	S 2 X NO Specif	ly:			Specify: Whit	- 0	
by the hospital or attending physician. be detached for use as the burial-transit permit. Pages 1, 2, at once.	ED .	15. DECEDENT'S EDU (Specify only highest grade	CATION	18e. DECEDEN	'S USUAL OCCUPAT	ION	16b.	KIND OF BUS	SINESS/INDUS		.е	
for us	Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	of work done during m use retired.)	oost of working						
the hospital detached fo	COMPLETED	7		Hous	ewife							
the hose detach	8	17. FATHER'S NAME (First, Middle, Last)	0.1.1			18. MOTHER'S NA						
	BE	James Edward	Smith			Daisey						
5 should	ဥ	19a. INFORMANT'S NAME (Type/Print) George W. Stanle	**			and Number or Rural				,		
		20a. METHOD OF DISPOSITION			9 WILLIAN	m St., Fr		1			-	
ector, pa		1X☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State ceme	etery, crematory of	r other place!		DATE	- 1	CATION — CIT		State	
Page 6 Indirecto		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	or Tubili I I I		AND ADDRESS OF FA			bron.	MD		100
after death. Page 6 may be by the funeral director, page moval.		* Hon	0//			oway Fune						
after by the moval.		23. PART Enter the diseases, or o	complications that assent	the death D	501 S	Snow Hill	Rd.	, Sali	sbury	, MD		
filled in by the on, or removal		anock, or neert fellure.	List only one sause on ea	ch line.					ratory arrea	ıt,	Approximate interval Betv	ween
y fille		IMMEDIATE CAUSE (Final disease or condition	CALORON	ting	Henri	1 Fac	· 0,, 1	P.			Onset and D	leath
completely fal, cremati		resulting in death)	DUE TO (OR AS A			1 / 000	w				-	
n certificate be executed within certificate by physician and completely fille Hygiene prior to burial, cremation, or other traumatic event, the	z		b.									
e be execute sician and carior to burial traumatic	CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE	OF):							
cate thysical	2	cause. Enter UNDERLYING CAUSE (Disease or Injury	c									
certificati ding phys tygiene p	Ë	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):							
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20-	AL	PART II. Other eignificant condition	e contributing to deeth bu	t not reculting	g in the underlyir	ng ceuse given in	Part i.	24a. WAS AN			ERE AUTOPSY FINDS	
s that pned by alth an	MEDIC						_	1 TYES 2	# NO	00	MPLETION OF CAU	
requires theen signed of Health										1	YES 2 NO	
has be Dept.	AN	DID TOBACCO USE CONT					N 🔲					
N: The ficate h State	S	EXAMINER? 1 YES 2 M'NO	HOSPITAL:		OTHER:							
PHYSICIAN: The law requires the this certificate has been signed with the State Dept. of Health riked, or Item 23 shows an	PHYSICIAN:	27. MANNER OF DEATH	1 Monpatient 2 ☐ ER/Outpa 28a. DATE OF INJURY			me 5 Residence			NJURY OCCU	nen.		
PHYS this on with with		1 Netural 5 Pending	(Month, Day, Year)		NJURY W	ORK?	200. 023	CHIDE HOW II	WART OCCU	NEU		
OR ATTENDING PHYS DIRECTOR: After this of hours after death with Item 28 is marked,	р ву	2 Accident Investigation 3 Suicide e Could not be	280. PLACE OF INJURY	— At home, terr			20t, LOC/	TION (Street a	and Number or	Rural Rout	e Number,	
CTOR: after 28 is	ETE	4 Homicide determined	building, etc. (Speci	7/)			City o	or Town, State)				
HOSPITAL OR ATTENDING PHYSICIAN: The law FUNERAL DIRECTOR: After this certificate has b within 72 hours after death with the State Dept. TANT: If Item 28 is marked, or Item 23	PLE	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowle	edge, desth occi	rred at the time, dat	a and place, and due	to the cau	ee(a) and man	ner se stated			-
HOSPITAL FUNERAL WITHIN 72 I	COMPL		R: On the basis of examination								d manner as state	ed.
TO THE HOSPI TO THE FUNER be filed within		296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI					onth, Day, Year)	
THE THE POPULATION TH	BE	Genjanin	H Meg	er		13073			▶ Z	1161	95	
0=	5	30. NAME AND ADDRESS OF PERSON WH BENTAMIN MEMOV	O COMPLETED CAUSE OF DEA	TH (ITEM 27) (7)	pe, Prigt)	13. SAR				7	. –	
					1151 57	13. SAG	13/3/1	7, M	0 2	1861	/	
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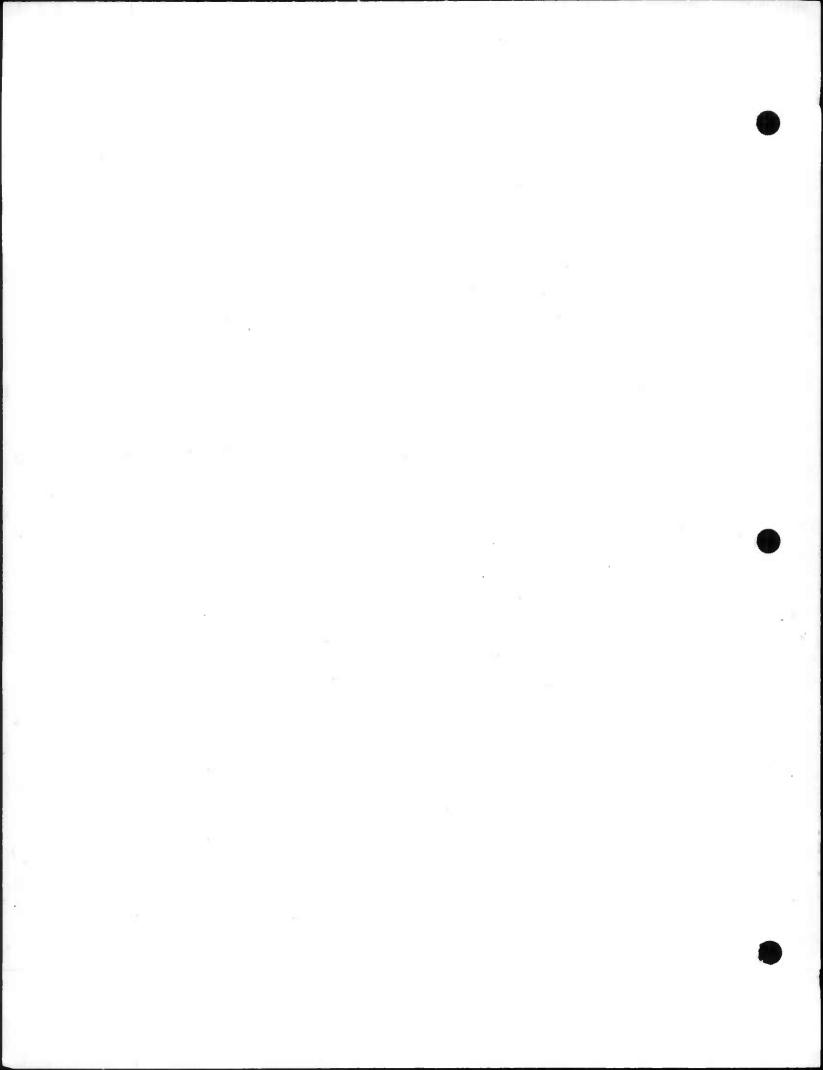
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

FOR 1 - STATE REGISTRAR	STATE OF	MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH	MENTAL HYGIS	
1. DECEDENT'S NAME (First, Middle, Last)	TOOPPU	CCT ANTWANT CO	2. DATE OF DEATH	DAY

	1. DECEDENT'S NAME (First	, Middle, Last)									2. DATE OF			Т	3. TIME OF DEATH
1	CHARLES		JOSEPH		SCIA	NIMA	NICC)			MONTH FARAL	D/		YEAR	0443 M
	4. SOCIAL SECURITY NUM	BER	5. SEX	8. AGE (f	n yrs. last	birthday)	IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF E	BIRTH	70,70	8. BIRTH	PLACE (State or Foreign
	054-10-573	35	1 □ M 2 □ F	8	8	YRS.	MONTHS	DAYS	HOURS	MIN.	April 6	1906	5	New	"York
	9n. FACILITY NAME (If not in	nstitution, give	street and number)	-			9b. CIT	Y, TOWN	OR LOCAT	ION OF D				NTY OF D	EATH
1 2	PENINSULA		AL MEDICA	AL CE	NTE	R		SALI	SBUR	Y			WIC	COMIC	0
DIRECTOR	RESIDENCE OF DE	10b. COUNT	Υ			10c, CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
뚬	Maryland	Wio	comico				alis								LIMITS?
	100. STREET AND NUMBER								I. ZIP COD	E		-	10g. CITI	ZEN OF W	THAT COUNTRY?
ER.	608 Irene	Ave.							218	301			USA		
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1								pecify Yes	or No-	14. RACE	- American Indian, White, efc.	
ВУ	1 Never Married 2 3 Wildowed 4 Divo		IF YES, GIVE V	WAR OR DA		1 ☐ YES 2 ☑ NO Specify:						Specifi	y:		
ED E		EDENT'S EDU		rmy	16- DEC	CEDENT'S	HOUAL C	COURT	ON					Whit	te
	(Specify on Elementary/Secondary (I	y highest grade	College (1-4 or 5		(Gh	ve kind of Do NOT u	work done	during me	st of world	ing	100. KIN	ID OF BUS	SINESS/IND	USTRY	
COMPLET	12	,	Conlege (1-4 of 5	"	P	1 umb	er				Plu	ımbin	12		
O.	17. FATHER'S NAME (First, M	liddle, Last)							18. MOT	HER'S NA	ME (First, Middl				
ш	Michael Vi		cianimani	СО					Do	meni	ica		Para	diso	
TO B	19a. INFORMANT'S NAME (Route Number, C			Code)	
-	Cheryl Ste		on	_						Salis	bury,				
	20a. METHOD OF DISPOSIT	on 3 🗆 Rem	novel from State	ceme	etery, cren	ND DATE	ther place						CATION —		
4 Donation 8 Other (Specify) Wicomico Memorial Park 2/23 Salisbury, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE								MD							
	Holloway Funeral Home														
\vdash	501 Snow Hill Rd., Salisbury, MD 21801 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate								MD 21801						
	ahock, or h	eert failure.	Complications the	t caused ise on ee	the dec	eth. Do i	not enter	r the mo	de of dy	ing, auc	h as cardiec	or respi	ratory err	eat,	Approximata interval Between
	IMMEDIATE CAUSE (Fig disease or condition		10.00	0											Onset and Death
	resulting in death)	→	a. ASUST	OR AS A	CONSEC	LIENCE O	EI.								Minules
z			b. Hyp												cnessy
[윤	Sequentially list condit if any, leading to imme	iona, diete	OUE TO	(OR AS A	CONSEO	UENCE O	F):	0							one DAy
<u>8</u>	cause. Enter UNDERLY CAUSE (Disease or Inju	ING	a. Acut DUE TO	0/	Ten	val_	Es	silu	e,	ACE	- indi	pin	1s A	an	one Dity
CERTIFICATION	that initiated events resulting in death) LAS	т	DUE TO	(OR AS A	CONSEQ	UENCE O	F):			pas	sible.	Seps	2.5		
岗			d												
	PART II. Other aignifice	ent condition	ns contributing to									. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL	GERK	7			-MR	certo	AT	Rush	Fibr	Male	1[YES 2			COMPLETION OF CAUSE OF DEATH?
Z.	Dement	is	ANXIG												1 TYES 2 NO
Ž	DID TOBACCO U		RIBUTE TO CA] UNC	CERTAI	NE				
PHYSICIA	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			E OF DEA	OTHE								
l¥	1 YES 2 NO	_	1/2 Inpatient 2 28a. DATE OF		rtiont 3	DOA 28b. TIM		28c. INJ		esidence	8 Other (Sp				
	Netural 5	Pending	(Month, D		- 1	INJ	URY M	WC	PRK?	□ NO	200. DESCHII	BE HOW II	NJUNY OCC	OHED	
ВУ	a D a state	Could not be	28a. PLACE O	F INJURY	— At hon	ne, farm,	street, fac				28f. LOCATIO	N (Street a	and Number	or Rurel R	oute Number,
臣		determined	building,	etc. (Speci	ty)						City or To	wn, State)			
1 1 1	29a. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best of	my knowle	edge, des	th occurr	ed at the	time, data	and place	, and due	to the cause(a) and man	noer as atat	ed.	
COMPLETED															and manner as stated.
l w l	29b. SIGNATURE AND TITLE	OF CERTIFIE	R						29c. LIC	ENSE NUI	WBER		29d. DATE	SIGNED	(Month, Day, Year)
TO B	2	10	140						P	39	803			1 -	100
F	30. NAME AND ADDRESS OF	F PERSON WI	O COMPLETED CAUS	SE OF DEA	TH (ITEM	27) (Type	Print)	_							
	MA	TKIN	5 1106	t RE	PALT	un	Ay	Dr	2) ve		AUS 1	MD	2	180	
	31. DATE FILED (Month, Day,	1 199!	O COMPLETED CAUSE 10 S 32. REGISTRA 5 Julia di	AUGULA	TURE	dell									
	ILDA	1 133	5 10												



USA

3. TIME OF DEATN

SELBYVILLE,

10d. INSIDE CITY

14. RACE --- American Indien, Black, White, etc.

1 YES 2 X NO

BLACK

Approximete interval Between Onset and Death

5 YVS

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO

1 YES 2 NO

211 95

COMPLETION OF CAUSE

6. BIRTNPLACE (State or Foreign

9:30 Am

DE

2. DATE OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MARY

68760
BOX
P.O.
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RECORDS,
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OF
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2

19 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF LINDER 24 HRS. 7. DATE OF BIRTH 021-22-8130 HOURS DAYS MIN. 1 M 2 X F 64 3 30 Pages 1, 2, 3 should 9e. FACILITY NAME (if not institution, give street end number) 9c. COUNTY OF DEATH WICOMICO 9b. CITY, TOWN OR LOCATION OF DEATH 35080 OLD OCEAN CITY ROAD PITTSVILLE, MD. DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION MD. WICOMICO **PITTSVILLE** permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 35080 OLD OCEAN CITY ROAD. 21850 be detached for use as the burial-transit retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 X Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: ВУ 3 Widowed 4 Divorced ETED | 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (So Elementary/Second College (1-4 or 5+) DOMESTIC HOUSE WIFE COMPL 18. MOTHER'S NAME (First, Middle, Melden Sumerne) ANNIE HOWARD 17. FATHER'S NAME (First, Middle, Last) EDWARD MARSHALL. SR. BE funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ADDRESS SAME AS ABOVE 2 WILLIAM SADBERRY a 9 20s. METHOD OF DISPOSITION
1A Burlet 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of commetery, cremen property and CRES 20c. LOCATION — City or Town, State Page 6 may must SELBYVILLE, DE. examiner 21. SIGNATURE OF EMNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL death. Southa 1213 JERSEY ROAD, SALISBURY, MD. 21801 be executed within 24 hours after devian and completely filled in by the full in burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart feiture. Liet only one cause on each line. IMMEDIATE CAUSE (Finel the disease or condition CONGESTAVE HEART FAILURE resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): DILATED CARDIOMYOPATHY traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate signed by the attending physician Health and Mental Hygiene prior to cause. Enter UNDERLYING SEVERE LV DYSFUNCTION CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): recuiting in death) LAST ö PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL (OPD ARRYTHMIA 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State 1, or Item OTHER:
4 | Nursing Home 5 | Reeldence 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 6 Other (Specify) 27. MANYER OF DEATN 26e, DATE OF INJURY this c 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending м 1 YES 2 NO ВҮ After death OR ATTENDING 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be DIRECTOR: / COMPLETED 4 Nomicide Item 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. TO THE HOSPITAL O
TO THE FUNERAL DI
DE filed within 72 ho
IMPORTANT: If Ite 2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner se stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE plat 42522 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Trakash R. Dalal

MD

614-D

32. ABGISTRAD'S SIGNATURE
Jaha Davelson Randall

Eastern

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

LOUISE MARSHALL SADBERRY

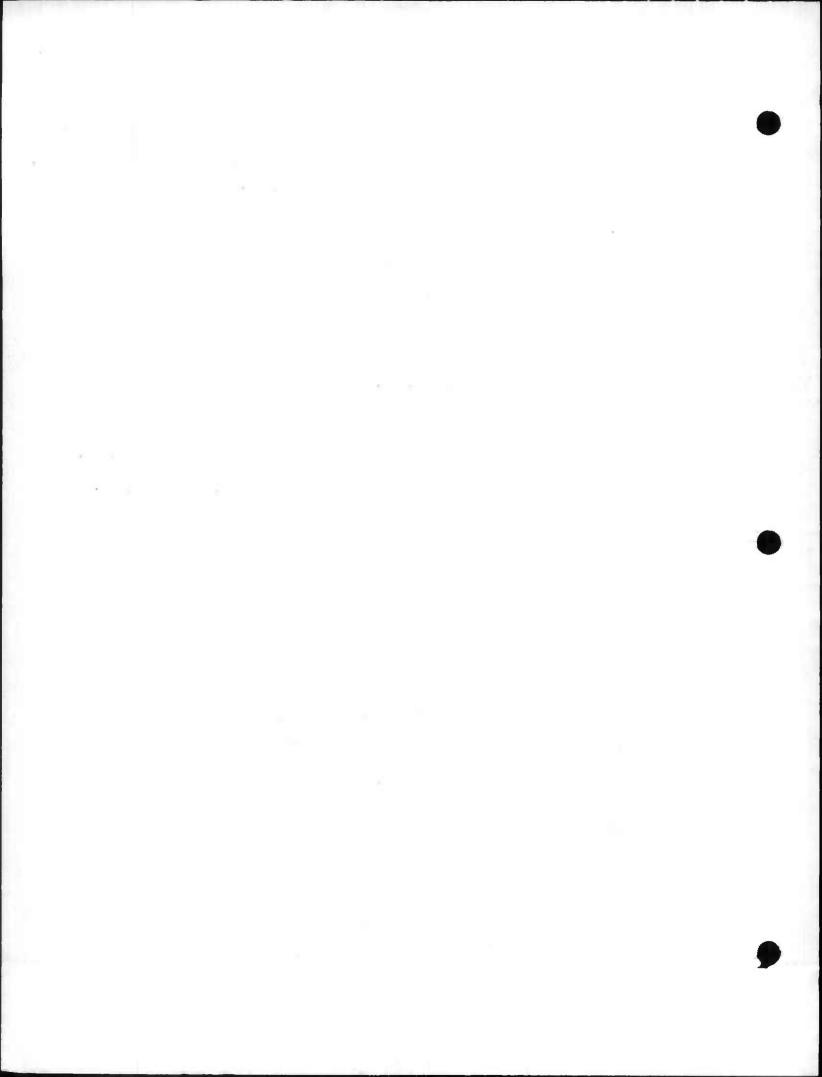
10

31. DATE FILED (Month, Day, Year)

FEB 21

1995

My 21801



(4/6) GA3-7762

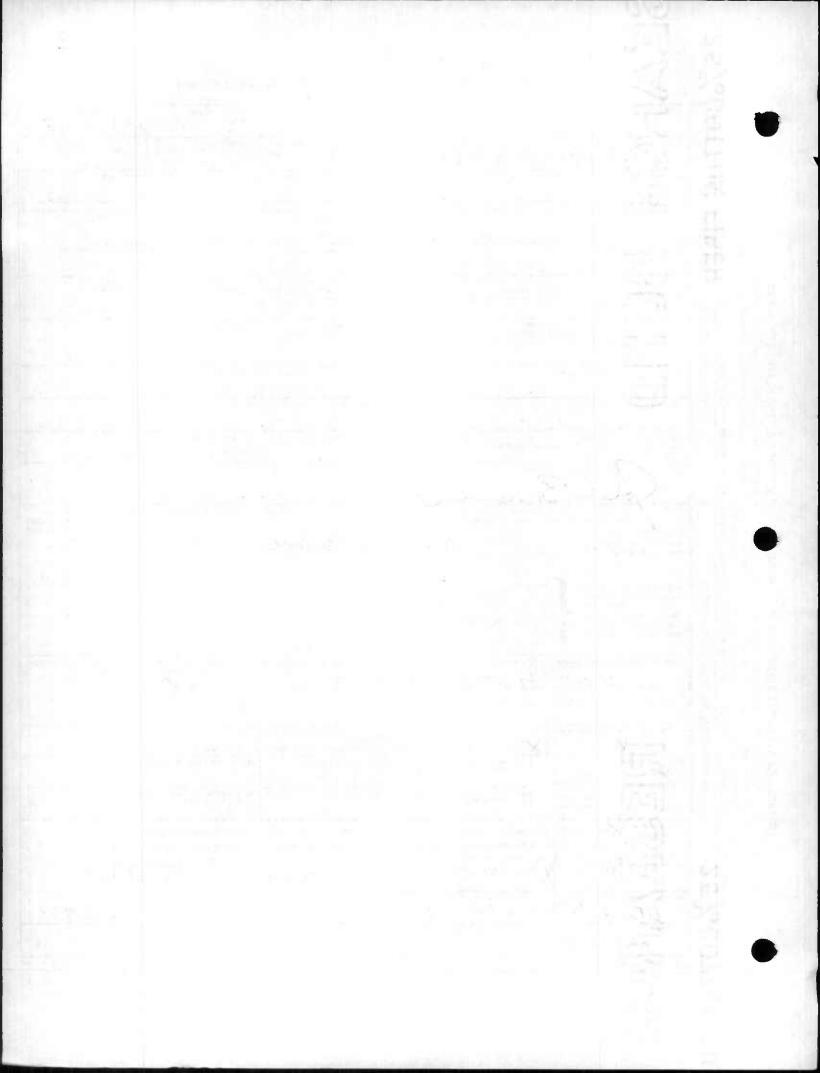
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1. DECEDENT'S NAME (First, Middle, Lest)	H. Sai			4-11-11	2. DATE OF DEATH	DAY YE	3. TIME OF DEAT
	4. SOCIAL SECURITY NUMBER		yrs. last birthday)			3 1	95	130.
	270 - 24 - A53	1 DM 2 OF 69		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 2 - 24 - 19	0	inthplace (State or Rountry) aryland
~	9a. FACILITY NAME (If not institution, give	street and number)	OT AS	9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH
DIRECTOR	Anne Arundel M	<u>ledical Ctr</u>		Anna	apolis		Anne	e Arunde
Sign 1	10e. STATE 10b. COUNT	Υ	10c. CITY	, TOWN OR LOCA	ATION			10d. INSIDE CITY
ä	MD Que	en Annes Co	0.	Chest	ter			LIMITS?
A	10e. STREET AND NUMBER			.1	OI. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
ER	302 Ellicott I				21619		USA	A
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 XWidowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	3 XNO	If yes, s		NIC ORIGIN? (Specify Yein, Puerto Rican, etc.)	1 2 2	RACE — American Indi- Black, White, etc. Specify: White
8	15. OECEDENT'S EDU	ICATION	16a. DECEDENT'S			16b, KIND OF BU	ISINESS/INDUSTR	
L .	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of w life. Do NOT us	ork done during n e retired.)	nost of working			
절	9		Homem	aker		Home	2	
COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Meider	Sumame)	
BE (Charles	F. God	o d		Hazel	Lee	Aller	1
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox		
	Anthony Wayne					Millers		
	20s. METHOD OF DISPOSITION 1 A Burlet 2 Cremetion 3 Rem	noval from State ceme	PLACE AND DATE Of tery, crematory or of	her place)			OCATION — City of	
	4 Donation 6 Other (Specify)	G I	len Hav	en Cen	The second second		en Bur	nie, MD
		2		22. NAME	AND ADDRESS OF FA	CILITY	495 R	itchie H
	John !	Jann		Barı	canco F.	H. Sever	na Par	ck MD 21
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events		CONSEQUENCE OF):	afure			3 de
EH	resulting in death) LAST	d						
DICAL C	PART II. Other algorificant condition	Cymphocytro	it not resulting l	n the underlyle	ng cause given in	Part I. 24a, WAS AI PERFO	RMED?	24b. WERE AUTOPSY F AVAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2
ME								
ME	25. WAS CASE REFERRED TO MEDICAL			26. 1	PLACE OF DEATH (Ch	eck only one)		
SICIAN: ME		HOSPITAL:	itlent 3 DOA	OTHER:		and the second of the second		
SICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: Mospital	28b, TIME	OTHER: 4 Nursing Ho	me 6 🗆 Residence	and the second of the second	INJURY OCCURE	D
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH Netural 5 Pending	T.V.		OTHER: 4 Nursing Ho F OF 28c. IN	me 6 🗆 Residence	6 Other (Specify)	INJURY OCCURE	D
ED BY PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH Netural 5 Pending	28a. DATE OF INJURY	28b. TiMi INJI	OTHER: 4 Nursing Ho E OF 28c. IN W 1	me 6 Residence	6 Other (Specify)	end Number or Ri	
ETED BY PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only)	28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY	At home, farm, s	OTHER: 4 Nursing Ho E OF 28c. IP WM 1 Irreet, factory, off	me 6 Residence HJURY AT YORK? YES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(e) and ma	end Number or Re	ural Route Number,
COMPLETED BY PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only)	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special S	At home, farm, s	OTHER: 4 Nursing Ho E OF 28c. IP WM 1 Irreet, factory, off	me 6 Residence JURY AT ORK? YES 2 NO Ice te end place, and due death occured at the	6 Other (Specify) 28d. OESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(e) and mutime, data and place, a	end Number or Re i) inner as stated, and due to the cau	ural Route Number,
BE COMPLETED BY PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Check only 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only One) 2 MEDICAL EXAMINI	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special S	At home, farm, s	OTHER: 4 Nursing Ho E OF 28c. IP W M 1 Irreet, factory, off	THE 6 Residence HJURY AT HORK? YES 2 NO Holice The end place, and due death occurred at the 29c. LICENSE NUI	6 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Yown, State to the cause(e) and mu time, data and place, a	end Number or Re i) inner as stated, and due to the cau	ural Route Number,
E COMPLETED BY PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Clan: To the best of my knowledge) ER: On the best of examination O COMPLETED CAUSE OF OEA	28b. TiMi INJI — At home, ferm, s edge, death occurre end/or investigation	OTHER: 4 Nursing Ho EOF 28c. It MY M 1 Interest, factory, off d at the time, dar n, in my opinion,	when 6 Residence NJURY AT YES 2 NO Ice te end place, end due death occured at the 29c. LICENSE NUI D78/5	8 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(e) and mutime, data and place, a MBER	end Number or Re	use(a) and manner ee a
BE COMPLETED BY PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Clans) ICIAN: To the best of my knowledge. The basic of examination	28b. TiMi INJI — At home, ferm, s edge, death occurre end/or investigation	OTHER: 4 Nursing Ho EOF 28c. It MY M 1 Interest, factory, off d at the time, dar n, in my opinion,	when 6 Residence NJURY AT YES 2 NO Ice te end place, end due death occured at the 29c. LICENSE NUI D78/5	6 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Yown, State to the cause(e) and mu time, data and place, a	end Number or Re	use(a) and manner ee a

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



1 STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH Thomas Stonestreet 10:10AM ehruarv 199 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) June 18, 1924 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreig Country) DAYS HOURS 1 M 2 F 220-62-6177 70 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Physicians Memorial Hospital La Plata Charles RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland 1 TES 2 NO St. Mary's Charlotte Hall permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? retained by the hospital or attending physician. 5 should be detached for use as the bunal-transit Rt. 1 Box 461 20622 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, stc. If yes, specify Cuben, Maxican, Puerto Rican, stc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married FORCES? 1 YES 2 Specify: B 3 Widowed 4 Divorced White ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 166. KIND OF BUSINESS/INDUSTRY (Specify only highe funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8 Agriculture Farmer 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) notified at Joseph Elmer Stonestreet Mabel Frances Jenkins BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Viola R. 1 Box 461 Charlotte Hall, Maryland 20622 Stonestreet hours after death. Page 6 may be must be 20s. METHOD OF DISPOSITION

VXSurisi 2 □ Cremetion 3 □ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Brayntown, Maryland Mary s Cemetery 3/3 4 Donation 5 Other (Specify) Benjamin M. Matthews M00658 medicai examiner 22. NAME AND ADDRESS OF FACILITY The Huntt Funeral Home, Inc. P.O. Box 156 Waldorf, Md. 20604 completely filled in by the rial, cremation, or removal, 23. PART i. Enter the diseesee, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate ehock, or heert feilure. List pnly one cause on eech line intervei Between IMMEDIATE CAUSE (Final **Onset and Daath** PATO_CELLULAR CARCENOMA the disease or condition that the death certificate be executed within resulting in death) or other traumatic event, bunal, CERTIFICATION and Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING the attending physician CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in deeth) LAST Mentai Injury. PART ii. Other eignificant conditione contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS by t BETES PERFORMED? AVAILABLE PRIOR TO MELL shows any been signed to pt. of Health a COMPLETION OF CAUSE t TYES 2 NO requires TENSLON 1 TES 2 NO PHYSICIAN: DID TOBÁCCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X has be Dept. 23 DR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item certificate by the State HOSPITAL OTHER: 1 - YES 2 NO 1 Kinpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Homs 5 Residence 6 Other (Specify) ö the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED with 1 marked, 1 Natural 1 YES 2 NO After 1 BY Investigation Accident 28a. PLACE OF INJURY — At home, farm, strest, fectory, office building, etc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town. State) 60 3 Sulcids COMPLETED 8 Could not be DIRECTOR: / 28 4 Homicide determined Item 29s. CERTIFIER t X CERTIFYING PHYSICIAN: To this best of my knowledge, death occurred at this time, data and place, and due to the cause(s) and manner se attated. TO THE HOSPITAL ITO THE FUNERAL EDGE filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the ation and/or investigation, in my opinion, death occured at the time, data and place, and dus to the cause(s) and manner as ateted. 29b. SIGNATURE AND TITLE OF CERTIFIER 19 S 29d. DATE SIGNED (Month, Day. 29c. LICENSE NUMBER BE 2-28-D-26064 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P . O . Box 282 Vidyasagar Anmangandla, M.D. Charlotte Hall, Maryland 20622 31. DATE FILED (Month, Day, Year) 32. BEGISTRAR'S SIGNATURE MAR 0 2 1995 Jalia Davideor Re

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

	REGISTRAN		OL.	-RIII	ICALE	. 01	DEA	111	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH	MY		3. TIME OF DEATH
	WILLIAM L	SHEPPA	ARD						FEBRUARY		YEAR	10:00 AM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF BIRTH			IPLACE (State or Foreign
	216-20-9512	17 M 2 🗆 F	68	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	026	Counti	ny)
	9a. FACILITY NAME (If not institution, give s		00	1110					Apr.21,1	_		MD
- I								ION OF DE	HTA	9c. COU	INTY OF D	EATH
DIRECTOR	THE JOHNS HOPKIN	S HOSPITA	L		BAL	TIM	ORE (CITY				
[ច្ច	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT									1		
E					Y, TOWN O						7	10d. INSIDE CITY LIMITS?
	MD Harf	ord		Hav	re o	de	Grac	ce				1 X YES 2 NO
I₹I	10e. STREET AND NUMBER					10	f. ZIP COD	E		10g. CIT	IZEN OF V	VHAT COUNTRY?
UNERAL	557 Girard St.						2107	78		ļ	US.	A [']
3	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARI	MED	13. V	WAS DEC	ENDENT (OF HISPAN	IC ORIGIN? (Specify Yes	or No-	14. RACE	— American Indian.
	1 Never Married 2 Married	FORCES? 1	YES 2 N	0	11				, Puerto Rican, atc.)		Biaci	k, White, etc.
à	IF YES, GIVE WAR OR DATES 3 Wildowed 4 Divorced Aug5, 1943 May 18, 1946 Specify: Specify: Aug5, 1943 May 18, 1946 Specify: Spec										Black	
ETED	15. DECEDENT'S EDU	CATION	16a. DEC	CEDENT'S	USUAL OC	CUPATION	ON		16b. KIND OF BU	SINESS/IN	DUSTRY	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +	- Illin	ve kind of i Do NOT u	work done d se retired.)	uring mo	ost of workli	ng				
14	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Consign (1-4 of 5 4		200	eamh]	37T.	inal	nen	. Automo	hila		
COMPL	17. FATHER'S NAME (First, Middle, Last)		Auce	JAS	CILLO	- У П	7		ME (First, Middle, Maiden			
1 - 1	Wendell Sheppa	rd					A 7777			Sumame)		
H		Iu							Kenly			
2	19a. INFORMANT'S NAME (Typa/Print)	7							oute Number, City or Tow			
	Mildred Sheppa	rd		o 7 G	irai	cd	St.	Hav	re de Gr	ace,	MD	
	20a. METHOD OF DISPOSITION 1.X. Burial 2 Cremation 3 Rem	oval from State	20b. PLACE A	ND DATE	OF DISPOSI	TION (Na	ame of		1	CATION -		•
	4 - Donation #9 Other (Specify)		St J	ames	Cer	n.			3-26 Hav	re d	le G	race,MD
	21. SIGNATURE OF PUNERAL SERVICE LI	softer /	//		22. N	AME A	ND ADDRE	SS OF FAC	SLITY			
	Vh. U.V.	. //	//						ral Home	_		
\vdash	(were 4	affin	4		- 5	552	L e	wis	St. Hav	re d	le G	RACE, MD
	23. PART I. Enter the diseases, or shock, or heart fellure.	complications that List only one cau	caused the dea	ith. Do r	not enter	the mo	de of dy	ing, auch	as cerdlec or respi	Iratory ar	rest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final											Onset and Death
	disease or condition resulting in death)	· anox	ac, bas	n	inter	IN	1					3 months
	rounding in death)	DUE TO	OR AS A CONSEO	UENCE O	F):	MY	7					JINOHINS
z		MALIO	cardin) in	Gan	ha	10					2 manins
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	CAVALO	UENCE O	n)	100	V .					JI WOUNT
X	cause, Enter UNDERLYING	Con	OR AS A CONSEO	alv	FINE	110	Onci	/				1 marker
프	CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSEO	UENCE OF	F):	CYL	ACKU SI					(III CON CON)
E	resulting in death) LAST				0							
핑		d										
	PART II. Other significent condition	s contributing to	death but not re	sulting	In the und	ieriyin	g cause g	given in f	Part I. 24s. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL	Linger agab	nintestma	I bleed	1 ma					PERFOR	V		AVAILABLE PRIOR TO COMPLETION OF CAUSE
		100	-1 -17 -0.02	7)					1 YES 2	E NO		DF DEATH?
Σ	DID TOBACCO USE CONT	DIDLITE TO CAL	ICE OF DEAT	THE ME	c Mi	10 [1 11110					1 - YES 2 NO
A I	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CA			TH (Check o		1 UNC	ERTAIN				
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER							
ΥS	1 TYES 2 NO	1 2 Inpatient 2		DOA			e 5 ☐ Re	esidenca (B ☐ Other (Specify)			
표	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, Da		28b. TIM INJ	E OF URY	28c. INJ WO	URY AT		26d. DESCRIBE HOW I	NJURY OC	CURED	
B	1 Netural 5 Pending 2 Accident Investigation				M	1 🗌 1	YES 2	NO				
	3 Suicide 8 Could not be	28a. PLACE OF	INJURY — A1 hon	na, term, s	street, lacto	ry, offic	•		281. LOCATION (Street a	and Number	or Rural R	loute Number,
Ξ.	4 Homicide determined	bulleting, t	are. (opocity)						City or Town, State)			
"	29a. CERTIFIER	CLAN: To the boot of										
₹ I									to the ceuse(a) and mar			
COMPLETED	2 MEDICAL EXAMINE	N. OII THE DEEM OF EX	aminucion and/or in	rvestigatio	n, in my op	inion, d	eath occur	red at the t	ime, data and placa, an	d due to th	ne cause(a)) and menner as stated.
w	286. SIGNATURE AND TITLE OF CERTIFIES						29c. LICE	NSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)
8	Inda & M	u mo					M	370	4	D 0	U27	495
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH (ITEM	27) (Туре,	Print)						1	1
	UNDA L. YAU T	OWER III	O JOH	NS +	tOPK1	NS	HOSP	ITAL	BALTIMO	RE 1	no :	21287
l li	31. DATE FILED (Month, Day, Year)	32 REDISTRAI	R'S SIGNATURE			- 0	1,000				, - 0	
	MAR U 2 1995	Jalia da	LIE SIGNATURE	Call								
		y	- consists with	TV				_				

95-0653-019

95 07985

FOR

Amended #18 4/21/95 TMT Talbot Co

	1 - STATE REGISTRAR	STATE UF IV			ICATE				IENTAL HYGIE REG. N				
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEATH	0.		3. TIME OF DEATH	
1	VIRGINIA	ELI	EANOR				SHAI	- 1	MONTH	0.7	95	8:40A M	
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last b	irthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE OF BIRTH	0 /		PLACE (State or Foreign	
	215-14-3329	1 M 2 X F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	(Morith, Day, Year) ULY 23,1	025	Countr	y)	
	9a. FACILITY NAME (If not institution, give	street and number)			9b, CITY	TOWN	R LOCATIO	ON OF DEA			UNTY OF D	RYLAND	
<u>۳</u>	722 WASHINGT	ON STREE	T						••••				
5	RESIDENCE OF DECEDENT	ON SIKEE	1		CAMBRIDGE						ORCH	ESTER	
DIRECTOR	10a. STATE 10b. COUN	TY		10c. CIT	Y, TOWN	R LOCAT	ION			10d. INSIDE CITY LIMITS?			
		RCHESTER		C.	AMBR:	[DGE				NX YES 2 ☐ NO			
₹ I	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	722 WASHINGTON S	TREET					21613	3		US	A		
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARME	D	13.	WAS DEC	ENDENT O	F HISPANIC	C ORIGIN? (Specify Y	ea or No-	14. RACE	- American Indian, White, alc.	
BY	3 Wildowed 4 Divorced	IF YES, GIVE W	YES ZYNO				YES 2XXNO Specify:				Specify:		
- 4	15. DECEDENT'S ED	IICATION	44- 0505	0511710							1	BLACK	
	(Specify only highest grad	de completed)	(Give	kind of	Work done (during mo	on st of workin	g	16b. KIND OF B	USINESS/IN	DUSTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	BORI					770			e	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		LA	BOKI	CK		10 MOTE	EO'S NAM	E (First, Middle, Maide	OL IC	E COM	IPANY	
	MARVIN COOPER						1111			Lh 1	. Vo	ene	
BE	19a. INFORMANT'S NAME (Type/Print)		19b. A	AILING	ADDRESS	(Street a			ute Number, City or R				
2	NEVADA BOULDEN								MBRIDGE,				
.!	20a. METHOD OF DISPOSITION		20b. PLACE AND	DATE	OE DIEBOE	ITION /A/a	mant	, CA		OCATION -			
	1 Donation 5 Other (Specify)	moval from Stata	cemetery, crema MADIS	SON	c FMF	TER	7	FER	11,1995			E. MD.	
i	21. SIGNATURE OF FUNERAL BERYINE L	ICENSEE				NAME AN	D ADDRES	S OF FACI	LITY				
	15		-	-					H FUNERAL				
\dashv	23. PART I. Enter the dieseses, or	complications that	caused the death	00.0	ot enter	P.() BC	X 16	87, EAST	ON, M	D. 21		
	shock, or heart feliure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. June	ea on aach line.						and leg			Approximata interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inflated events resulting in daeth) LAST	C	OR AS A CONSEQUE										
ICAL (PART ii. Other aignificent condition	na contributing to	deeth but not read	ulting	In the un	derlying	ceuse g	iven in Pa		N AUTOPSY	24b.	WERE AUTOPSY FINDINGS	
5							_		_ 1 YES	2 NO		AWAILABLE PRIOR TO COMPLETION OF CAUSE	
MED												OF DEATH?	
z	DID TOBACCO USE CONT	TRIBUTE TO CAL	JSE OF DEATH	I YE	S 🔲 8	10 🗆	UNC	ERTAIN			1		
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE C	OF DEAT									
Š	1XX ES 2 □ NO	HOSPITAL:	ER/Outpatient 3 🗆	DOA	OTHER		NX.	sidenca 8	Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF I	NJURY 2	8b. TIM	E OF URY	28c. INJU	JRY AT	, 3	Red. DESCRIBE HOW	INJURY OC	CURED	1	
à	1 Natural 5 Pending 2 Accident Investigation	Fard2/4/	95 9	_	4 LM	1 🗌 Y		NO	Subje	ct s	6-07		
	3 Suicide 8 Could not be determined	politica, a	INJURY — At home, ic. (Specify)		street, facto	ory, office	,	2	28f. LOCATION (Street City or Town, State	and Numbe	r or Rural R	oute Number, Carlos P	
COMPLETED		A	2 seden	CR					722 Wa	shop	mst	rel marglet	
릴		SICIAN: To the heat of a											
۶Į	2 MEDICAL EXAMIN	ER: On the heats of exa	unination and/or inve	ettgetto	n, in my o	pinion, de	ally occurs	d at the tin	ne, dete and piece, a	nd due to t	he cause(s)	and manner as stated.	
BE	296. SIGNATURE AND TITLE OF CENTIFIE	n 1 11	/					NSE NUMBI		29d. DAT	E SIGNED	Warth, Day Year)	
2	30 NAME AND ADDRESS OF PERSON WI	M. Kin	y wo				C	.C.N	7.E.	•	FEB.	08, 95	
		KING	And the second distriction						200				
	31. DATE FILED (Month, Day, Year)	Penn St	.Baltim		e, M	ary	land	212	201				
	FFB 1 7 1995	Jalan Mark	Gor Radal										
		June 10											

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

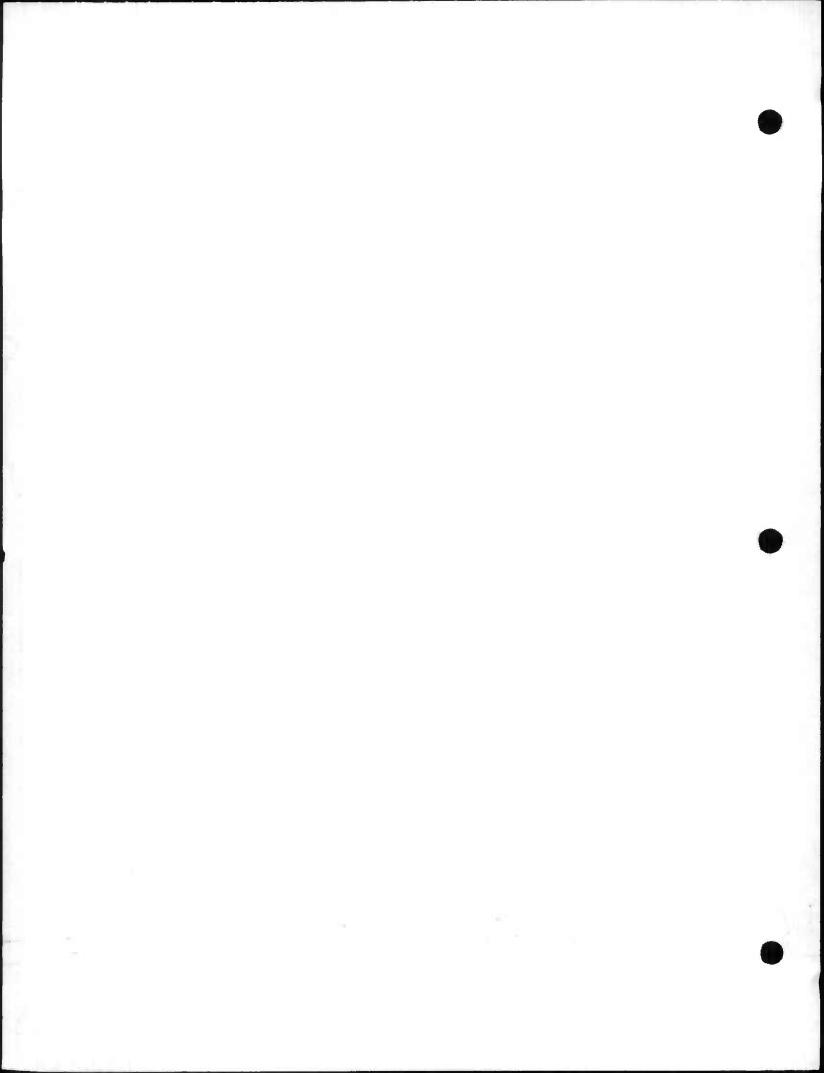
s.... 30g v 187.

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mentai Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.	
DIVISION OF VILAL RECORDS, P.O. BOX 68/60	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / D	EPARTMEI RTIFICAT	NT OF H	EALTH AND	MENTAL HYGIE			
	1. DECEDENT'S HAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH
1		ma Cather	ine	Smigoc	ki		February	23, 19	YEAR	3:45 PM
	577 00 7070		'In yrs. last bi	MONTH	DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			IPLACE (State or Foreign
			3	YRS.	DATS	HOURS MIN.		1921		ington D.C.
c .	9a. FACILITY HAME (If not institution, give stre	-				R LOCATION OF D	DEATH	9c. COUN	TY OF D	EATH
DIRECTOR	Holy Cross Hospita	.1			Silve	r Sprin	g	M	lont	gomery
I W	10e. STATE 10b. COUNTY		1	IOC. CITY, TOWN	OR LOCA	ION				10d. IHSIDE CITY
		tgomery		Silve	r Spr	ing			_]	LIMITS? 1 X YES 2 NO
FUNERAL	10e. STREET AND HUMBER				101	. ZIP CODE		10g. CITIZ	EN OF V	VHAT COUNTRY?
핗	409 Penwood Road					2090			US.	A
	1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 ZNO	D 1	If yes, sp	ecify Cuban, Mexic	NIC ORIGIN? (Specify) an, Puerto Rican, etc.)	es or No	Black	— American Indian, c, White, etc.
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR D	ATES	_	1 TYES	2 X HO Speci	ffy:		Speci	^{%:} White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION (moleted)	16a. DECEL	DENT'S USUAL	OCCUPATION	ON at an article	16b, KIHO OF B	USIHESS/IHDU	ISTRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	kind of work don NOT use retired	e during mo	st or working				
MP	12		Home	maker			Own Ho			
	17. FATHER'S HAME (First, Middle, Last)						AME (First, Middle, Maide	n Sumeme)		
BE	Spencer Dean 190. INFORMANT'S NAME (Type/Print)		105.00	IAN INC ADDRE	00 (0)		ice Hall Route Number, City or R			
임	Timothy Smigocki						Pike Burt			MD 20066
	20e. METHOD OF DISPOSITION	20b		DATE OF DISP				OCATION - C		
	1 N Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State com	ateny cremet	long or other plac	o.l					g.Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIGHT	ISEE		2	2. NAME AP	D ADDRESS OF F	ACILITY			
1	De Colorado la la	Touch			ranc 500 H	15 J. UC niversit	ollins Fun y Blvd.W.	eral H	ome	, Inc.
	23. PART i. Enter the diseases, or con	mplications that caused	the death	n. Do not ent	er the mo	de of dying, suc	ch as cardiac or res	piratory arre	st,	Approximate
	ahock, or heart feliure. Lie iMMEDIATE CAUSE (Final	at only one cause on e	ech ilne.						War E	interval Between Onset and Death
	diagram on accediate	Cardiopulme	onary	Arres	t					5 Minutes
		DUE TO (OR AS A	CONSEQUE	HCE OF):						Jimaces
Z	Sequentially list conditions, b.	Adenocarci	noma (of Unkı	nown	Primary	Site			7 Months
AT	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	COHSEQUE	HCE OF):						
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUE	NCE OF):						
CERTIFICATION	resulting in deeth) LAST									
	PART II Other significant conditions	a and other day of a set to		data di ad						
CAL	PART II. Other aignificent conditions	contributing to geath b	ut not rest	Jiting in the	underlying	ceuse given in		N AUTOPSY PRMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
E						<u> </u>	1 🗆 YES	2 X NO		COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDICA	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	E DEATH	VES TY	NO F	UNCERTAI	N D			1 TYES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE O	F DEATH (Chec		ONCERIAL	Т			
Sic	EXAMINER? 1 YES 2 XHO	IOSPITAL: Ñ Inpatient 2 ☐ ER/Outp	atient 3 🗆	DOA 4 N		5 🗆 Reeldence	6 Other (Specify)			
	27. MAHHER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		8b. TIME OF	28c, IHJ		28d. DESCRIBE HOW	INJURY OCCU	JRED	
ВУ	1 Accident 5 Pending Investigation	(1101111)		M		ES 2 NO				
ED	3 Suicide 6 Could not ba 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— Al home,	farm, street, fa	ctory, office		26f. LOCATION (Stree City or Town, State		r Rural R	oute Number,
COMPLET	29e. CERTIFIER (Check only one)	AN: To the best of my knowl	edge, death	occurred at the	time, date	end place, and due	to the cause(s) end m	enner ae statec	1,	172
S	2 MEDICAL EXAMINER:	On the basis of examination	end/or Inve	stigation, in my	opinion, d	eath occured at the	time, date end place, o	and due to the	CSUSO(S)	end menner ee stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NU		29d. DATE	SIGHED	(Month, Day, Year)
10	AND MARKE AND COMMENT	sleo				D10690		Feb	rua	ry 23, 1995
	30. NAME AND ADDRESS OF PERSON WHO						1 1 00	200		
	Edger Levin 9801 Ge	20. REGISTRAR'S SIGNA	#341	Silve	r Sp	ring, Ma	ryland 20	902		
	FFR 28 1995		P							
	- FEB WV 1995	THUR WRUGUS	CFLOROLO	И						



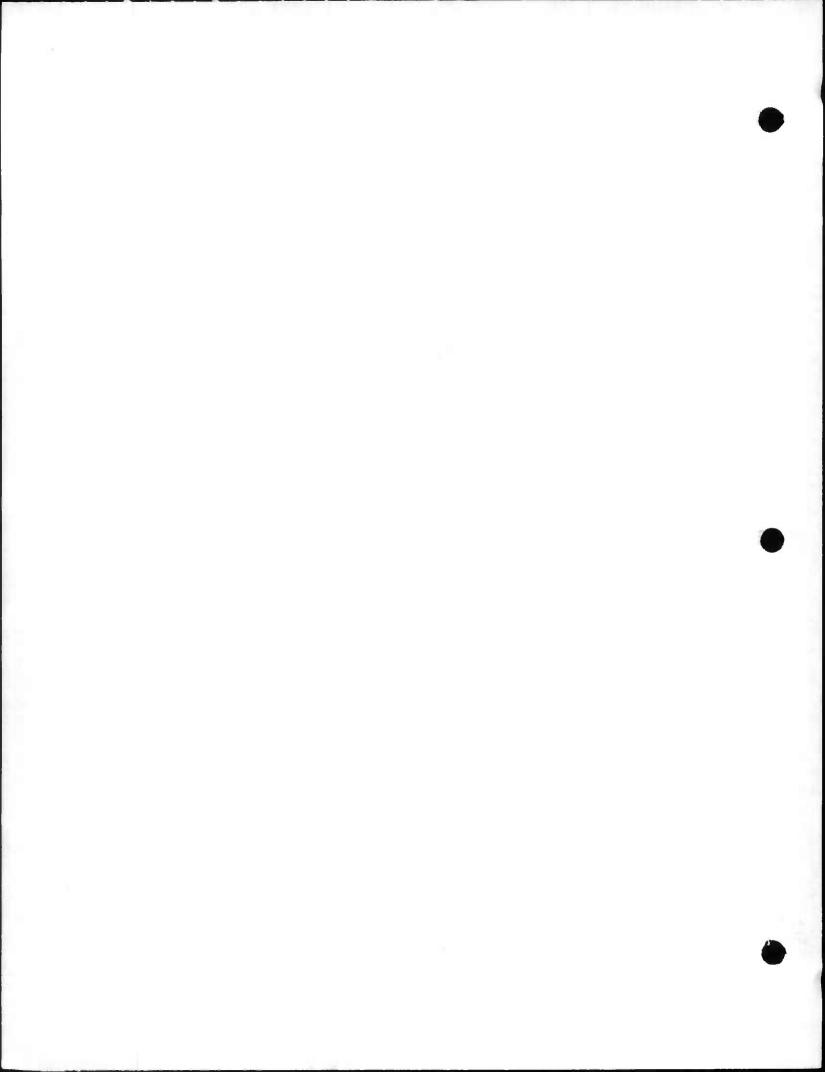


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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept of Health and Mental Hydiene prior to burial cremation or removal
-

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)	Carl Hart Schaaf				2. DATE OF DEATH FEDRUARY 24, 1995 3. TIME OF DEATH 11:30P M			
BE COMPLETED BY FUNERAL DIRECTOR	127-24-9757	4-9757 1 🖾 M 2 🗆 F 83 YRS. MONTHS (IF UNDER 24 HRS. HOURS MIN.	Jan. 14,1912		ATTHPLACE (State or Foreign unity) Indiana	
	96. FACILITY NAME (If not institution, give street and number) 3525 Twin Branches Drive							Montgomery	
	10e. STATE 10b. COUNTY 10c. CITY, TO			•	town on Location lver Spring			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	10e. STREET AND NUMBER 3525 Twin Branches Drive			10f, ZIP CODE 20906			10g. CITIZEN OF WHAT COUNTRY? USA		
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	Never Married 2 Merried FORCES? 1 YES 2 MNO		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Mexican, Puerto Rican, etc. 1 YES 2 NO Specify:			Yes or No- 14. RACE — American Indien, Black, White, etc. Specify: White		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 5+ United Nati			vork done during ri se retired.)	ring most of working				
	17. FATHER'S NAME (First, Middle, Last) Albert H. Schaaf				18. MOTHER'S NAME (First, Middle, Malden Surneme) Bertha Hart				
5	190. INFORMANT'S NAME (Type/Print) Barbara Schaaf 190. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 3525 Twin Branches Drive Silver Spring MD 20906								
	20e. METHOD Of-DISPOSITION 1 Duriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 2/27/95 Alexandria, Va.								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins F 500 University Blvd.							Sil.Spr.		
BY PHYSICIAN: MEDICAL CERTIFICATION	ahock, or heart feliure. List only one ceuse on each line.						Approximata Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events reaulting in deeth) LAST b. OUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other algorificant conditions contributing to death but not resulting in the underly Ventricular Arrythmia			n the underlyin	PERFO		MED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES N			S [] NO [UNCERTAIN	1 D YES 2 1 NO		OF DEATH?	
	25. WAS CASE REFERREO TO MEDICAL EXAMINER? Solution								
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ten			E OF 28c. IN	INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED WORK?				
						281. LOCATION (Street of City or Town, State)	OCATION (Street end Number or Rural Route Number, by or Town, State)		
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(e) end menner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(a) end menner as stated.								
TO BE C	200. SIGNATUME AND TITLE OF CENTISER				29c. LICENSE NUMBER D21334		29d. DATE SIGNED (Month, Dey, Year) ▶ February 27,1995		
	Daniel Goldberg M.D. 10401 Old Georgetown Road Bethesda MD 20814								
31. DATE FILED (MONTH, Day, Your) 32. REGISTRAR'S SIGNATURE FEB 28 1995 Julia Shubler Refell								DHAH. 16 Say 190	



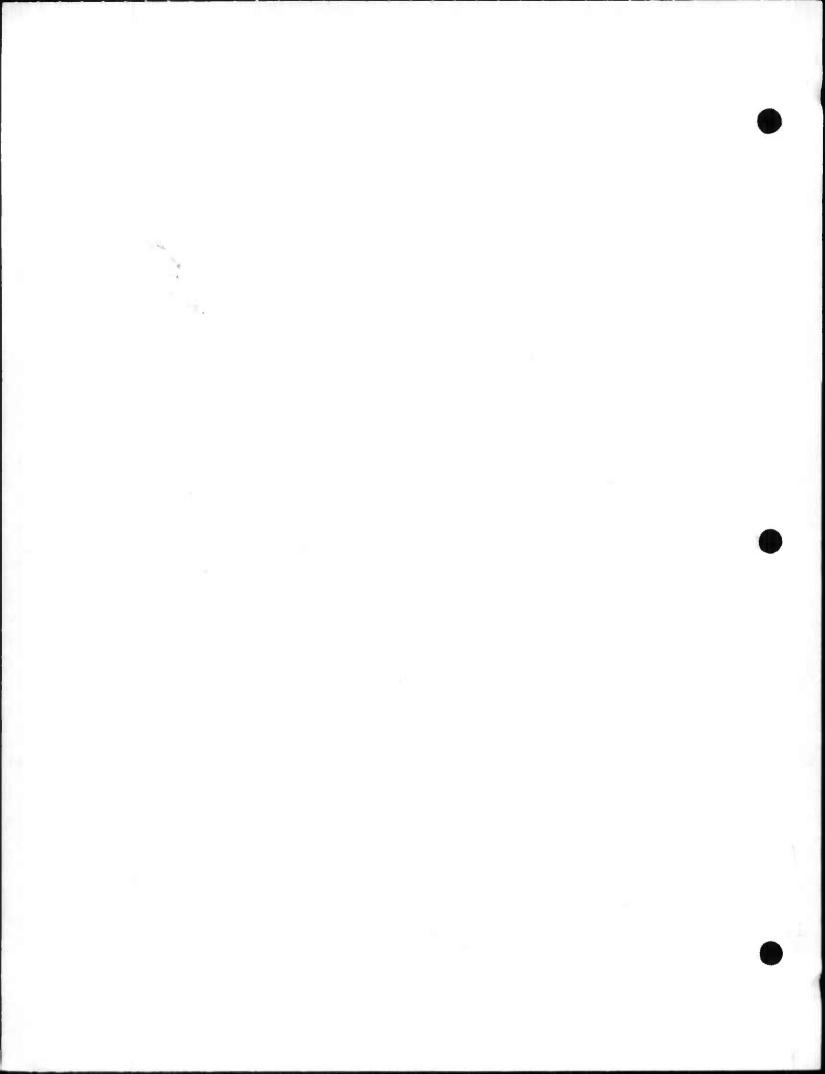


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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filled within 72 hours after death with the State Dent, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Amended	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN	1.
1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN CERTIFICATE OF DEATH	

95	0	7	9	8	8
Con	n	+	y		

	4 DECEMBER 15 MARKE 15	14444				10/11		DEA			ied. NO			
	1. DECEOENT'S NAME (First	Geor	ge G.			S	zarv	as		2. DATE OF MONTH Feb. 24	DEATH	95	YEAR	5:15 a m
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In vi	s. last birthday		ER 1 YEAR	_	R 24 HRS.	7. DATE OF I		7	e Biotul	PLACE (State or Foreign
	577.74.5034		1 XXM 2 □ F	75.71	A	MONTH		HOURS	MIN.	(Month, Da	ly, Year)	a	Country	gary
	90. FACILITY NAME (If not in	nstitution, give st	reet end number)	-		PRS. Dec. 5, 1919 Hi								
OR	7101 Oak		t Lane			Bethesda Montgome								
딦	RESIDENCE OF DEC	10b. COUNTY			100 0	10c, CITY, TOWN OR LOCATION 104 INSIGE C								THE STATE OF THE S
DIRECTOR	Maryland		tgomery			l "							10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
	10e. STREET AND NUMBER		<u> </u>					H. ZIP COD	E			10g, CIT		HAT COUNTRY?
FUNERAL	7101 Oak	Forres	t Lane					20	0817				.S.A	
בַּ	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S		1:	3. WAS DE	CENDENT C	OF HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indien, White, etc.
B	1 Never Merried 2 X		IF YES, GIVE W					S 2 X NO		n, Puerto Ricer	1, #IC.)			White
	15. DEC (Specify onl	EDENT'S EDUC y higheat grade	CATION completed)	164	. DECEDENT (Give kind o	f work don	e durina m	ION ost of working	ng	16b. KIN	D OF BUS	SINESS/INC	DUSTRY	
Elementery/Secondary (0-12) College (1-4 or 5+) L/														
Elementery/Secondary (0-12) College (1-4 or 5 +) +4 Electrical Engineer I. B. M. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)														
Forenc Szarvas Rosa Leopold 19e. INFORMANT'S NAME (Type/Print) Agatha Szarvas 7101 Ools Forence of Number of Rural Route Number, City or Yown, State, Zip Code)														
Agatha Szarvas 7101 Oak Forrest Lane Bethesda, Md. 20817												.7		
20a. METHOD OF OISPOSITION 1 Burlel 2 Cremetlon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)												n, State		
4 Donation 5 Other (Specify) Mt. Comfort Crematory 2/25 Alexandria, Va. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE												a.		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH Gawler's Sons 5130 WI AVE NW WASHINGTON DC 20016													
	23. PART I. Sinter the d	iseases, pr c	omplications that	caused the	e death. Do	not ante	er tha mo	oda of dy	ing, suci	h as cardiec	or reapi	retory arr	reat,	Approximata
	IMMEDIATE CAUSE (Final Onset and Death													
-	disease or condition reaulting in death)	→ ,	METT	ASTA	TIC	Pr	osta	Te	Car	reino	ma	7	_	5years
,			DUE TO	(OR AS A CO	NSEOUENCE	OF):								
CERTIFICATION	Sequentielly liet conditi		OUE TO	(OR AS A CO	NSEOUENCE	OF):								
<u>정</u>	cause. Enter UNDERLY! CAUSE (Disease or inju													
	thet initiated events resulting in deeth) LAS	Ţ	DUE TO	OR AS A CO	NSEOUENCE	OF):								
₹∥	PART II. Other significa	nt conditions	contributing to	deeth but n	ot resulting	in the u	ınderiyin	g ceuse g	given in	Pert I. 24a	. WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL	Corona	14 X	42TER	ey d	1864	L				10	YES 2	-		COMPLETION OF CAUSE DF DEATH?
Σ														1 TYES 2 NO
Z I	DID TOBACCO U		IBUTE TO CA						ERTAIN	1 🗆 📗				
HYSICIAN:	EXAMINER?	O MEDICAL	HOSPITAL:		PLACE OF DE	OTHE	R:					11		
Ĕ	27. MANNER OF DEATH		1 Inpetient 2 I		18 3 U DOA		Y	JURY AT	sidence	28d. DESCRIE		110	m+	
<u> </u>		Pending Investigation	(Month, De	ry, Year)		IJURY M	W	YES 2	NO	200. DESCRIE	SE HOW IF	IJUHY OCC	UHED	
B 0	3 Sulpida	Could not be	28e. PLACE OF	F INJURY A	t home, farm	street, fe	ctory, offic	:0		28f. LOCATION	N (Street e	nd Number	or Rural Ro	ute Number,
4 Homicide determined City or Town, State)														
29e. CERTIFIER (Check only one) 1														
Š	one) 2 MEOI	CAL EXAMINER	: On the basis of ex	amination end	t/or investigat	lon, in my	opinion, o	death occur	ed at the	time, date end	place, end	due to th	e ceuse(e)	end menner ee stated.
H H	29b. SIGNATURE AND TITLE	OF CERTIFIER	0					age. LICE	NSE NUM	BER		29d. DATE	E SIGNED (Month, Day, Year)
5	T. all	2001	MD					D	31	317		1	1/2	4/95
	30. NAME AND ADDRESS OF Loreto Albid						ue #	105	Beth	esda,	Md.2	0817		
ľ	31. DATE FILED (Month, Day,		32. REGISTRAI	R'S SIGNATUR	RE							JJ1/		
	FEB 28	1995	Juli Da	dear Ro	rdell									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

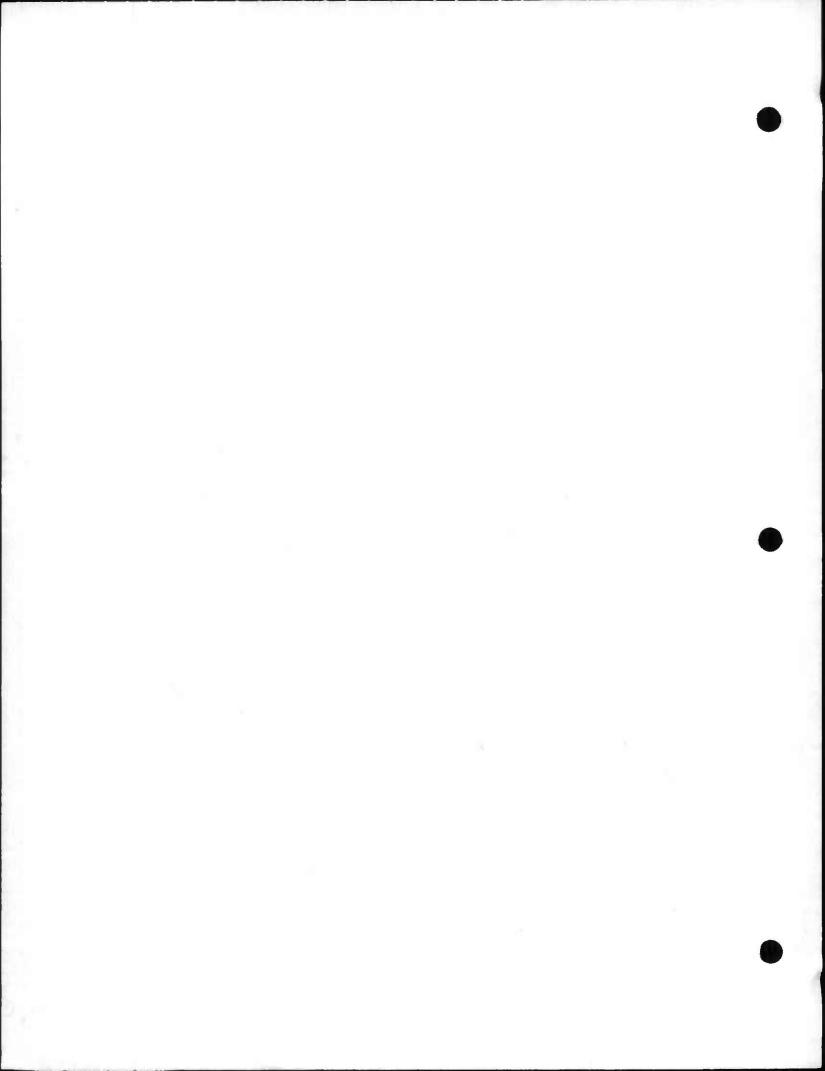
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

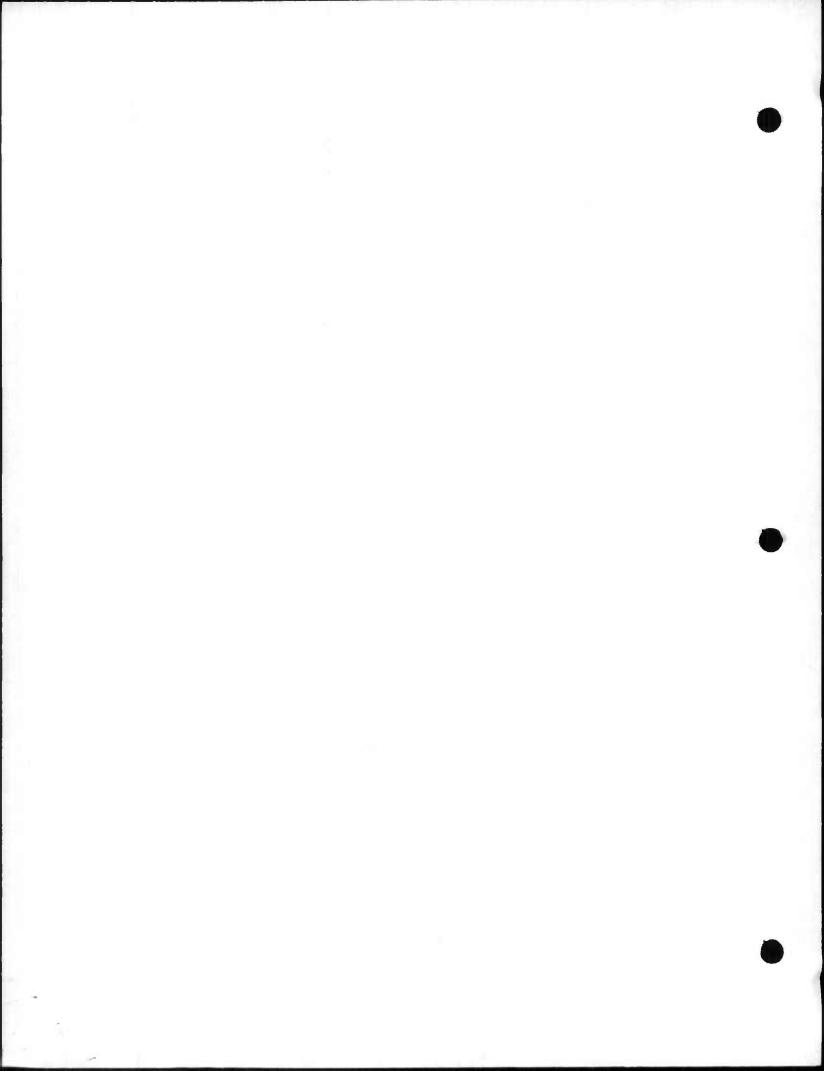
FOR 1 - STATE REGISTRAR

	REGISTRAR		C	-niii	ICATE U	F DEA	I II	REG. NO).				
	1. DECEDENT'S NAME (First, Middle, Lust, Don		0.					2. DATE OF DEATH MONTH D	MY	YEAR	3. TIME OF DEATH		
		Carl		fen				Feb. 22	19	995	6:52 P M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER 1 YEA		R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Countr			
	485-32-3483	1 🔀 M 2 🗌 F	66	YRS.	reb. 26, 1928 16								
-	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE							EATH		
DIRECTOR	Holy Cross Hospi	tal			Silve	r Spri	ing		Mor	ntgom	ery		
l C	10a. STATE 10b. COUNT	ТҮ		10c. CIT	Y, TOWN OR LO	CATION					10d. INSIDE CITY		
1 8	Maryland Mont	gomery		Si1	ver Spi	cinc					LIMITS?		
	10e. STREET AND NUMBER	5002)		1 011	VCI DP	101. ZIP COD	F		10a CD	TIZEN OF W	VHAT COUNTRY?		
FUNERAL	12806 Gaffney Roa	ad				2090			log. or	USA			
Ž	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WAS (ECENDENT (DE HISPANI	IC ORIGIN? (Specify Yes	or No.		- American Indian.		
	1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 1	10	If yea,	specify Cube	ın, Mexican	, Puerto Rican, etc.)	0 01 110-	Black	t, White, etc.		
B	3 Wildowed 4 Divorced	1946 -				E9 2 🔁 NO	Specify.			Speci	White		
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION (e. completed)	16a. DE	CEDENT'S	USUAL OCCUPA	TION		16b. KIND OF BU	SINESS/IN	DUSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5 +	·) life.	Do NOT us	vork done during se retired.)	most or works	rig						
Z Z	12	4	Ph	otog	rapher			Self-	-emp1	.oyed			
8	17. FATHER'S NAME (First, Middle, Lest)							NE (First, Middle, Maiden	Surname)				
BE													
0													
-			12	806	Gaffney	Road	, Si	lver Sprin	ng, M	lary1	and 20904		
	20a. METHOD OF DISPOSITION 1 □ Burial 2 🔀 Cremation 3 □ Rer	novat from State	20b. PLACE	AND DATE	OF DISPOSITION	(Name of				City or To			
	4 Donation 5 Other (Specify)		Fort	Linc	oln Cre			2/24 Brer	twoo	d, Ma	aryland		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITHINES—Rinaldi Funeral Home 11800 New Hampshire Avenue												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	23. PART I. Enter the diseases, or	complications the	caused the de	ath. Do r	ot enter the	node of dy	ing, such	as cardiac or reap	iratory as	rest,	Approximate		
1 .	ahock, or heart failure	. List only one ceu			- (Interval Between		
1 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) • This public Cordiomyoputuy Onset and Death												
	resulting in death)	OUE TO	(OR AS A CONSE	DUENCE OF	F):	ONE	PUP	aluy					
z			•				1	,					
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	DUENCE OF									
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	C											
트	that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF	7:								
EH	resulting in death) LAST	d											
	PART II. Other significant condition	ns contributing to	deeth but not r	esulting	n the underly	ing cause	alven In F	Part I. 24s, WAS AN	ALITOREY	1 041	WERE AUTOPSY FINDINGS		
EDICAL				oouting .	ii die dideriy	my cause	given iii r	PERFOR		240.	AVAILABLE PRIOR TO		
								1 YES 2	XNO		OF DEATH?		
Σ	DID TOPACCO HEE COAD	DIDLITE TO CA	UCE OF DEA	TIL VE	C 🗆 110			34	*		1 TES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONT 25, WAS CASE REFERRED TO MEDICAL	KIBUIE IO CA			H (Check only or		ERTAIN						
100	EXAMINER?	HOSPITAL:			OTHER:								
5	27. MANNER OF DEATH	28a. DATE OF		28b. TIM		Ome 5 Re		Other (Specify)					
	1 Natural 5 Pending	(Month, De		INJ	URY	WORK?		26d. DEŞCRIBE HOW I	NJURY OC	CURED			
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유	4 Homicide 8 Could not be	building,	etc. (Specify)	1170, 10T111, 1	Areet, rectory, or	new		281. LOCATION (Street a City or Town, State)	and Numbe	r or Hurel H	oute Number,		
COMPLET	29a. CERTIFIER			-									
M M	(Check only							o the cause(a) and mar					
8	2 MEDICAL EXAMIN	ER: On the besis of ax	amination and/or i	nvestigatio	n, in my opinion	, death occur	red at the ti	lme, data and place, en	d due to t	he cause(s)	and menner as stated.		
BE (296. SIGNATURE AND TITLE OF CERTIFIE	R	-	1		29c, LICI	ENSE NUME	BER	29d. DA1	E SIGNED	(Month, Day, Year)		
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-	30. NAME AND ADDRESS OF PERSON W			pring .			01		2		1. 1		
		WIND, 10	1313 6	eon	914 1	ve,	Sil	ver Spi	rius	1	u		
	31. DATE FILED (Month, Day, Year)	33. REGISTRA	R'S SIGNATURE	100				U	0				
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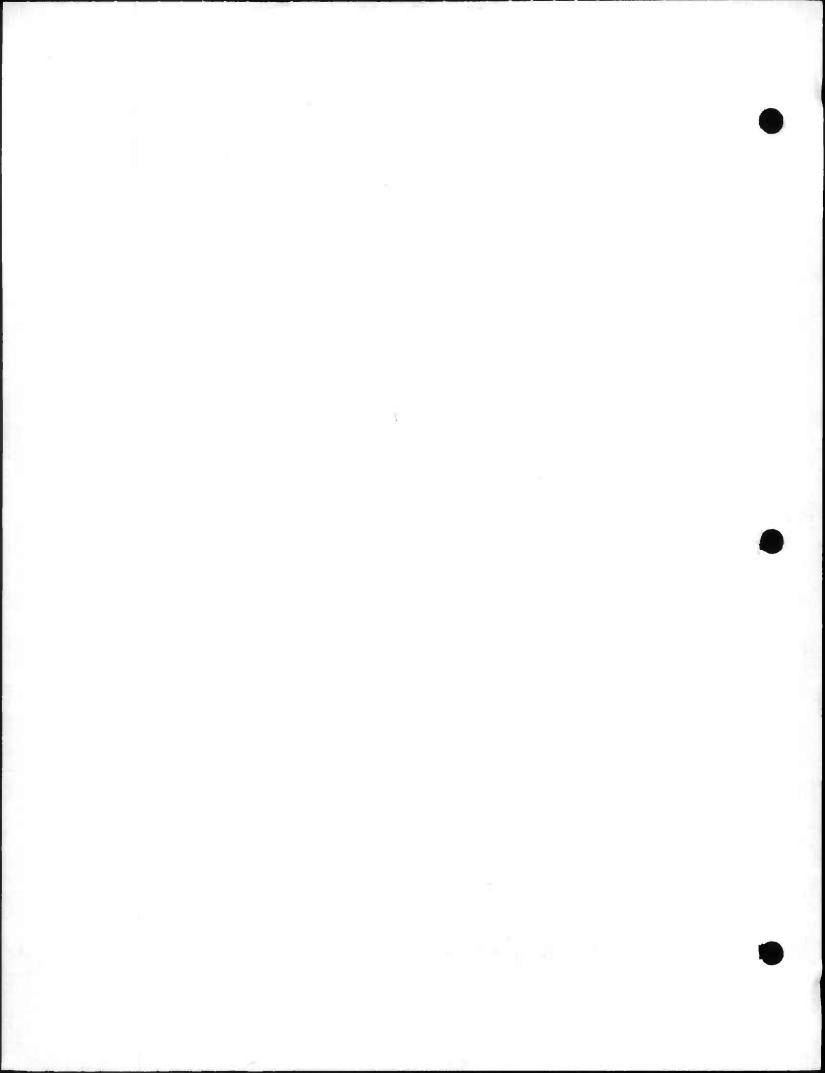
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		4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. I		IF UNDER	1 YEAR	IF UNDER	MIN.	7. DATE OF BIRTI	H ar)	8. BIRTH Countr	HPLACE (State or Foreign	
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should	1 00	Sensington			~ II					ON OF DEA	TH	9c. COL	INTY OF D	EATH	
23	DIRECTOR	RESIDENCE OF DE		nd Nulsin	g nome	ome Kensington					Montgomery				
Jes 1,		10e. STATE	10b. COUNT	Υ	_	10c. CIT	Y, TOWN C	OR LOCA	TION					10d, INSIDE CITY	
8	1 #	Maryland	Montg	gomery		Silver Spring								LIMITS?	
permit. Pages	A A	10e. STREET AND NUMBER				101. ZIP CODE					10g. CITIZEN OF W				
75	E E	1112 Chick	asaw D	rive		20903						1	USA		
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS		12. WAS OECEDEN	T EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPAI 14. WAS DECENDENT OF HISPAI 15. WAS DECENDENT OF HISPAI 16. WAS DECENDENT OF HISPAI 17. WAS DECENDENT OF HISPAI 18. WAS DECENDENT OF HISPAI 18. WAS DECENDENT OF HISPAI 19. WAS DECENDENT OF HI					OF HISPANIC	ANIC ORIGIN? (Specify Yes or No. 14, RACE			E American Indian,	
5-0020 nding physic is the burial	BY F	1 Never Married 2 3 Wildowed 4 1 Div		IF YES, GIVE W		NO			yes, specify Cuban, Maxican, Puerto Rican, atc.) ☐ YES 2 ☑ NO Specify:				Speci		
5-0 anding				1									25,000	White	
121 or afte	COMPLETED	(Specify on	CEDENT'S EDU ly highest grade		1	Give kind of	vork done i	CCUPATION during mo	ON ost of working	ng	16b. KIND OI	F BUSINESS/IN	DUSTRY		
D 21 pital or od for u	٦	Elementary/Secondary (0-12)	College (1-4 or 5+) _	ite. Do NOT use retired.) Secretary					N T	TT			
N Post	MO S	17. FATHER'S NAME (First, A	Aiddle, Last)			ecret				NED TO NAME	N. I. H. NAME (First, Middle, Maiden Surrame)				
1 6 8 E	-	Samuel Max									Cusick	siden Sumame)			
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-tran	BE	19a. INFORMANT'S NAME (Type/Print)	-		9b. MAILING	ADDRESS	(Street a			ute Number, City o	r Town State 7	n Codel		
		Barbara Sul	livan											vland 20003	
nay be		200 METHOD OF DISPOSIT			20b. PLACE	1112 Chickasaw Drive, Silver Spring, Mar									
OR HOR		163 Burtal 2 Cremation 3 Ramoval from State Company of the place 12/25 Lynchburg, Variable 12/25 Lynchburg, Va													
TIN Page In		21. SIGNATURE OF FUNERA	AL SERVICE LA	CENSEE	//		22.	NAME A	O ADDRES	SS OF FACIL	wwHines-	-Rinald	li Fu	neral Home	
BALTIMORE, I sher death. Page 6 may be by the funeral director, page smoval.		Manis	The	11 X- X	1000	m		TRU	New	7 Hami	shire A Maryla	Avenue			
B nours after d in by the or removal		23. PART i. Enter the d	lisesses, or	complications thet	caused the d	eath. Do r	ot enter	the mo	de of dvi	ing such	Platy 18	and ZU	904	Approximate	
d in		snock, or r	lesit lellure.	List only one caus	se on each iln	10.		17				copilatory at		interval Between	
n 24 fy fills		iMMEDIATE CAUSE (Fi	nei		EPT	70	KN	1/	4					Onset and Death	
s760 tted within 24 completely file ial, cremation,		disease or condition resulting in death) s.											70975		
		_		. URI	WAR	1/	TR	AC	7	11/2	FITT	ON		1 YEAR	
P.O. BOX 68' h certificate be execut anding physician and c Hydiene prior to burie	ERTIFICATION	it only, leading to initiationate													
BOX cate be en hysician a	<u>S</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury													
O Bing B	E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
ORDS, P.O. BOX that the death certificate be ed by the attending physician h and Mental Hygiene prior to the box Inlinity or other training.		d													
CORDS, res that the dea signed by the att eatth and Merita	4	PART ii. Other significa	ent condition	s contributing to	deeth but not	resulting	n the un	derlying	ceuse ç	given in Pa		S AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS	
Signed by the Health and Inc.	EDICAL	HEM	IPLE	G/A;	CER	REBRAL INFARC-						RFORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE	
111 2 N T 3											_			OF DEATH? 1 YES 2 NO	
AL RE has been a Dept. of P		DID TOBACCO U	ISE CONT	RIBUTE TO CAL	USE OF DE	ATH YE	S 🗆 N	10 C	UNC	ERTAIN					
VITAL IAN: The law rificate has the State Dept	\ S S	25. WAS CASE REFERRED T	O MEDICAL	HOSPITAL:	26. PLA	CE OF DEAT									
SICIAN: The certificate the State		1 TYES 2 NO		1 Inpetient 2	ER/Outpatient	3 DOA	4 Nur		e 5 🗆 Re	sidence 6	Other (Specify)				
OF VI. PHYSICIAN: this certification with the St	. T	27. MANNER OF DEATH	D 4.	28a. DATE OF (Month, Da		28b. TIM	E OF URY	28c. INJ WO	URY AT	2	8d. DESCRIBE H	OW INJURY OC	CURED		
ON O DING PHYS After this death with	À	2 Accident	Pending Investigation				М		/ES 2 [NO					
ATTENDING STORE: After death		3 Suicide 8 4 Homicide	Could not be determined	28a. PLACE OF building,	INJURY — At h atc. (Specify)	ome, farm, a	treet, facto	ory, offic		2	8f. LOCATION (St City or Town, S	reet and Number State)	r or Rural A	loute Number,	
DIVISION OR ATTENDING F DIRECTOR: After t hours after death	<u> </u>	an arminan i							_						
D TAL O	MP.			CIAN: To the best of i											
TO THE HOSPITAL TO THE FUNERAL De filed within 72		2 MED			amination and/or	Investigatio	n, in my o	pinion, d	eath occur	red at the tin	me, data and plac	e, and due to II	he cause(s)) and manner as stated.	
THE PORT	BE	296. SIGNATURE AND TITLE	OF CERTIFIE	4		m	1		29c. LICE	ENSE NUMBI	ER ALLO	29d, DAT	E SIGNED	(Month, Day, Year)	
223	0	men	11/	· MM	1	111	U_1		DI	Ude	14/	1 -	EB.	23,1995	
	-	0. NAME AND ADDRESS O	PERSONWH	O COMPLETED CAUS	E OF DEATH (ITE	Λ		200	An	0	1 4 4		20.		
		31. DATE FILED (Month, Day,	Vene	32. REGISTRAF	V / K/-	116 6	HES	MA	mi). X	0814	-/ 10	14		
		0	Di Della	1											
		FER 27	1995	Jalia d'Aux	dior Rost	all									



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		4E HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death cert	FRAI
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	DIVISION OF VITAL RECORDS, P.O.	ATTE	prima
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	A	mended # / #95 #18 # 195 3/2/95 MRT Montgomery Ch. 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN 3. TIME OF DEATN										
		ARTHUR Thomas SULLIVAN FEBRUARY 27, 1995 6:53 A										
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. list birthday) 1X M 2 F 84 4. SOCIAL SECURITY NUMBER 1 YEAR IF UNDER 24 HRS. 1X M 2 F 84 4. SOCIAL SECURITY NUMBER 1 YEAR IF UNDER 24 HRS. 1X M 2 F 84 4. SOCIAL SECURITY NUMBER 1 YEAR IF UNDER 24 HRS. 17. DATE OF BIRTH OCCUPATION OF PROBLEM OF FOREIGN OF FORE										
2, 3 should	ror	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH MONT.										
if. Pages 1,	DIRECTOR	PRESIDENCE OF DECEDENT 100. STATE 100. COUNTY MARYLAND MONTGOMERY 100. CITY, TOWN OR LOCATION 100. INSIDE CITY LIMITS? 1 YES 2 Y NO										
nsit perm	FUNERAL	106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 20815 U.S.A.										
-0020 ling physician. the burial-transit permit.	B	11. MARITAL STATUS 1										
MARYLAND 21215-0020 retained by the hospital or attending physician. S should be detached for use as the burial-tran outlifted at once.	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ACCOUNTANT BROKERAGE FIRM										
MARYLAND retained by the hospit 5 should be detached notified at once.	ш	17. FATHER'S NAME (First, Middle, Last) ARTHUR BULL SULLIVAN 18. MOTHER'S NAME (First, Middle, Meiden Surname) HELEN HAYNES LIV MOTH										
60 40	TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUZANNE S. VAUPEL 1011										
ORE 6 may rector, pa		20e. METHOD OF DISPOSITION 1 Burlal ** Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Specify Completely, Complet										
* BALTIN nr death. Pag the funeral of note. nt examiner		21. SIGNATURED FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOS. GAWLER'S SONS INC. 5130 WI AVE NW WASHINGTON, D.C. 20016										
EASED TO GAWLERS * P.O. BOX 68760 ath certificate be associated within ref hours at mending physician and companiety filled in by at Hygiene prior to barrial, commartion, or send or other traumatile event, the medical	CERTIFICATION	23. PART I. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO/OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): GUE TO (OR AS A CONSEQUENCE OF): GUE TO (OR AS A CONSEQUENCE OF): GUE TO (OR AS A CONSEQUENCE OF):										
CCO Signed Health Health	MEDICAL O	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A FORESC (PYORY 1 VES 2 NO 248. WAS AN AUTOPSY FINDINGS MARK BILL PRIOR TO COMPLETION OF CAUSE OF BEATHY 1 VES 2 NO										
TAL The law	PHYSICIAN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN \$\frac{1}{2}\$. Was case reference to medical examiner? 1 \(\text{Y YES } 2 \) NO 1 \(\text{Inperient } 2 \) EVOURDation 1 \(\text{Inperient } 2 \) EVOURDation 1 \(\text{Inperient } 2 \) EVOURDation 1 \(\text{Inperient } 3 \) OOA 25. Was case reference to medical examiner? 1 \(\text{Inperient } 2 \) PLACE OF DEATH (Obeck only one) 26. PLACE OF DEATH (Obeck only one) 27. Was case reference to medical examiners and the second of the control										
PHYSIC OF MAN IN SEC.	BY PHY	27. MANNER OF DEATH 28s. DATE OF INJURY (MONT), Day, Year) 28s. DATE OF INJURY (MONT), Day, Year) 28s. DATE OF INJURY (MONT), Day, Year) 28s. DATE OF INJURY (MONT), Day, Year) 28s. DATE OF INJURY (MONT), Day, Year) 28s. DATE OF INJURY (MONT), Day, Year) 28s. DATE OF INJURY (MONT), Day, Year)										
DIVISION OR ATTENDING DIRECTOR: After hours after death Item 28 is man	COMPLETED	3 Succide 6 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										
HOSPITAL FUNERAL WITHIN 72		(Check only One) 2 MEDICAL EXAMINER: On the basia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. See Enter this Check only One in the basia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
TO THE TO THE De filed WMPOR	TO BE	29d. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) February 27, 1995 MANA ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
100		John B. Umhau, Jr. 8805 Connecticut Ave. Chevy Chase, Md. 20815 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE										

FFB 28 1995 Juli Studien Roll



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR		STATE OF M	ARYLAN	D / DEPAR					MENTAL	HYGIEN REG. NO	E			
	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE	OF DEATH			3. TIME OF DE	ATH
	DOROTHY		71.	א זאזא			CO	IIT 7.0	,	MONTH	D		YEAR		
	4. SOCIAL SECURITY NUMBER	FR		NNA	's, last birthday)			HLAC		FE		199		4:50	Ам
			1.01	o. AUE (III YI	,,	IF UNDER 1	DAYS	IF UNDER	24 HRS.	7. DATE ((Month)	Dey, Year)		8. BIRTH Countr	IPLACE (State or i	Foreign
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	9a. FACILITY NAME (If not ins	titution, give a	treet and number)			9b. CITY, 1	TOWN (R LOCATIO	ON OF DE	ATH			NTY OF D		
S.	#14-2 DEW	MOOD	COLLDA			DERWOOD						N/) NIMIC	OMEDY	
5	RESIDENCE OF DEC	EDENT	COURT			LDEI	ZWO	עט				IVI	DIN I G	OMERY	
DIRECTOR	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN OR	LOCAT	ION						10d. INSIDE CIT	γ
<u> </u>	Maryland	Mont	gomery			Derwoo	ρd						- 1	LIMITS?	T NO
	10e, STREET AND NUMBER	11011	-gomery			DCIWO	-	. ZIP CODE			-	40. 077			Z 140
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FUNERAL	14 Dew Wo	od Coi						208					ited	States	
5	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yea, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — Arm Black, White											— American Inc.	llan,		
BY	3 Widowed 4 Divor		IF YES, GIVE W					2 NO			rount, atta.)		Speci		
														White	
COMPLETED	15. DECE (Specify only	DENT'S EDUC	CATION completed)	161	. DECEDENT'S	USUAL OCC	UPATIO	N et of weekin	_	16b.	KIND OF BUS	SINESS/INC	DUSTRY		
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<u></u>	12			S	ervice	Deli	C1	erk			Groce	777 S	tore		
S O	17. FATHER'S NAME (First, Mid	idle, Last)				DOIL	- 01		ED'S NAS	AE /Eirot A/	iddle, Maiden		COLE		
	Eli	Можо	erd ob					10							
BE	19a, INFORMANT'S NAME (TV)	Maro	VICH		400 0000 000					Anı		ımmul			
2	13,										er, City or Town				
	Paula S. Orr				14 De	w Woo	d C	ourt	, De	rwood	d, Mar	ylan	d 20	855	
	20a. METHOD OF DISPOSITION 1 M Buriel 2 Cremation	ON 3. □ Remo	oval from State	20b. PL/	ACEANDDATE	OF DISPOSIT	ION (Ne	me of		OATE	20c. LO	CATION —	City or To	wn, State	
	4 Donation 5 Other (Grai	y, cremetory or and order	Cemet	ter	y		3/2	Nort	h Ve	rsai	lles, P	Α.
	21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE	. 0		22. N/	AME AN	O ADDRES	S OF FAC	YLITY	D 17 3	77			
	l →XX, Q	. (11.	. OU	à.						DeVo1	. Fun	eral	Home	
	Journ	en	0.0		cus	110	E.D	eer 1	Park	Dr.	. Gait	hers	burg	, MD. 2	0877
	23. PART i. Enter the dis	esaaa, or c	omplications that List only one caus	caused the	death. Do	not antar ti	ha mo	da of dyle	ng, auch	as cardi	ac or reapi	ratory an	reat,	Approxin	
- 1	IMMEDIATE CAUSE (Fina		and dring only budge	o on auch	mie.									Onset an	
	disease or condition resulting in death)	*	INTRAU	FRED	RAL. 1	hour	RR	14736	=						
	resulting in death)				NSEQUENCE O			0	<u> </u>						
,														i	
RTIFICATION	Sequentially list condition		DUE TO (OR AS A COI	NSEQUENCE O	FI:								-	
4	if any, leading to immedicause. Enter UNDERLYIN					,								j	
윤	CAUSE (Disease or injur	y \$ '	DUE TO (OR AS A COL	NSEQUENCE O	D.								-	
≣	that initiated eventa resulting in death) LAST		552.10(JII NO A 001	NOEUUENUE U	r).								ì	
- 1	PART II. Other significan	t condition	contributing to	leath but n	ot resulting	in the unde	arlylno	CRUSA	lvan in S	Part I	24a. WAS AN	ALITOROV	1 000	WEDE ALTONOMY	
EDICAL							,	ondoc g		ure i.	PERFOR		240.	WERE AUTOPSY I	TO
5										- 1	1 YES 2	□ NO		OF DEATH?	CAUSE
Ĭ										= 1				1 YES 2	NO
	DID TOBACCO US	E CONTR	IBUTE TO CAL	ISE OF D	EATH YE	S D N	0 🗆	UNC	ERTAIN						
ĕ	25. WAS CASE REFERRED TO	MEDICAL		28. F	PLACE OF DEAT	TH (Check on	ly one)								
PH TSICIAN:	EXAMINER?		HOSPITAL:	FR/Outpatier	# 3 □ DOA	OTHER:		e37 n							
	27. MANNER OF DEATH		28a. DATE OF II		28b. TiM	4 Nursin	8c. INJU				RIBE HOW II	11107 00	211222		
	1 Netural 5 P		(Month, Day		INJ	URY	WO	RK?		LOU. DEŞC	MOE NUW I	WORLD OCC	DUNEO		
2		vestigation	00 DI 105 05					ES 2	-						
3		ould not be	28a. PLACE OF building, a	ic. (Specify)	u nome, farm, :	ereet, lactor	y, office	ı		281. LOCA City or	TION (Street a Town, Stete)	nd Number	or Rural R	oute Number,	
7.6	29a. CERTIFIER 1 CERTIF	FYING PHYSIC	DIAN: To the beat of m	y knowledge	e, death occurre	ed at the time	e, data	and place,	and due t	o the caus	e(a) and men	ner as stat	ed.		
5			R: On the beele of exa											end manner ea	stated.
ا د	PANTURE AND TITLE O														
N	(Marie	And I V	0.10					29c. LICE	NSE NUMI	BER		29d, DATI	E SIGNED	(Month, Day, Year)	
, II	W. AMBACO	The contract of the contract o	THE STATE OF THE S				1	0							

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

· KOROU um

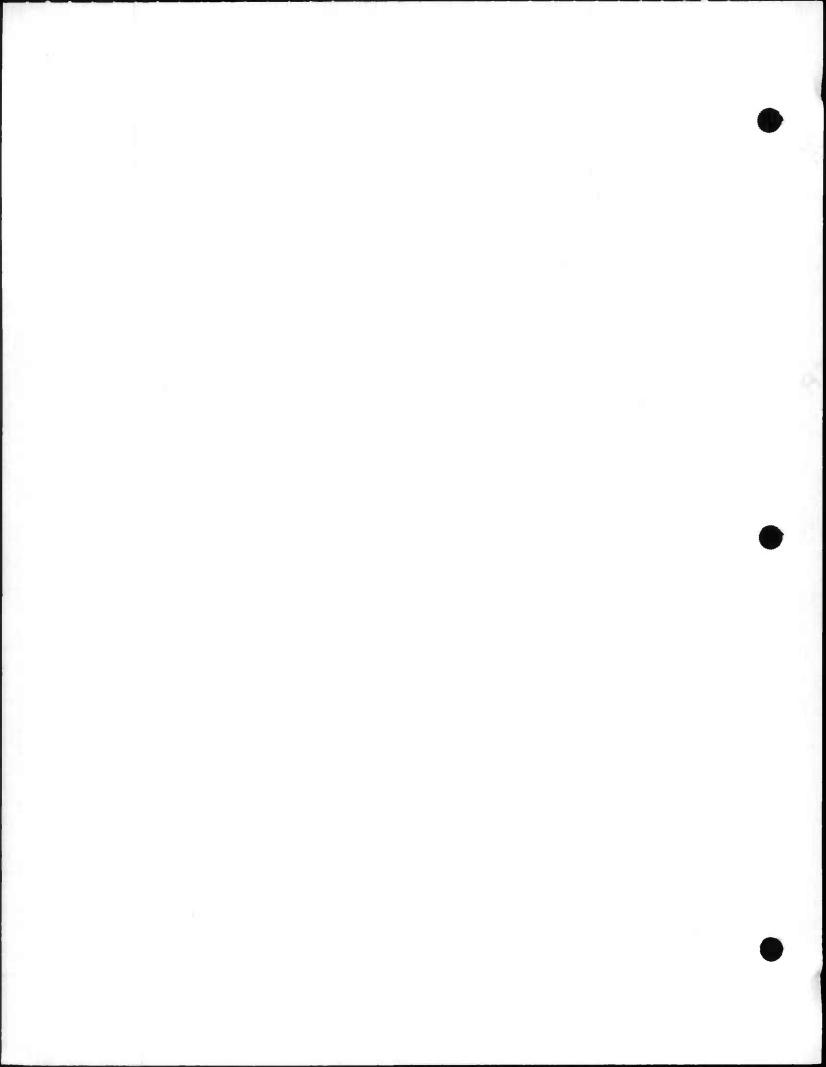
111

32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MAR 02

OHMH-18 Rev 1/89

Penn Street, Baltimore, Maryland 21201



11:12P

YEAR 1995

2. DATE OF DEATH MONTH DAY FEBRUARY 23,

WARD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

SINCLAIR

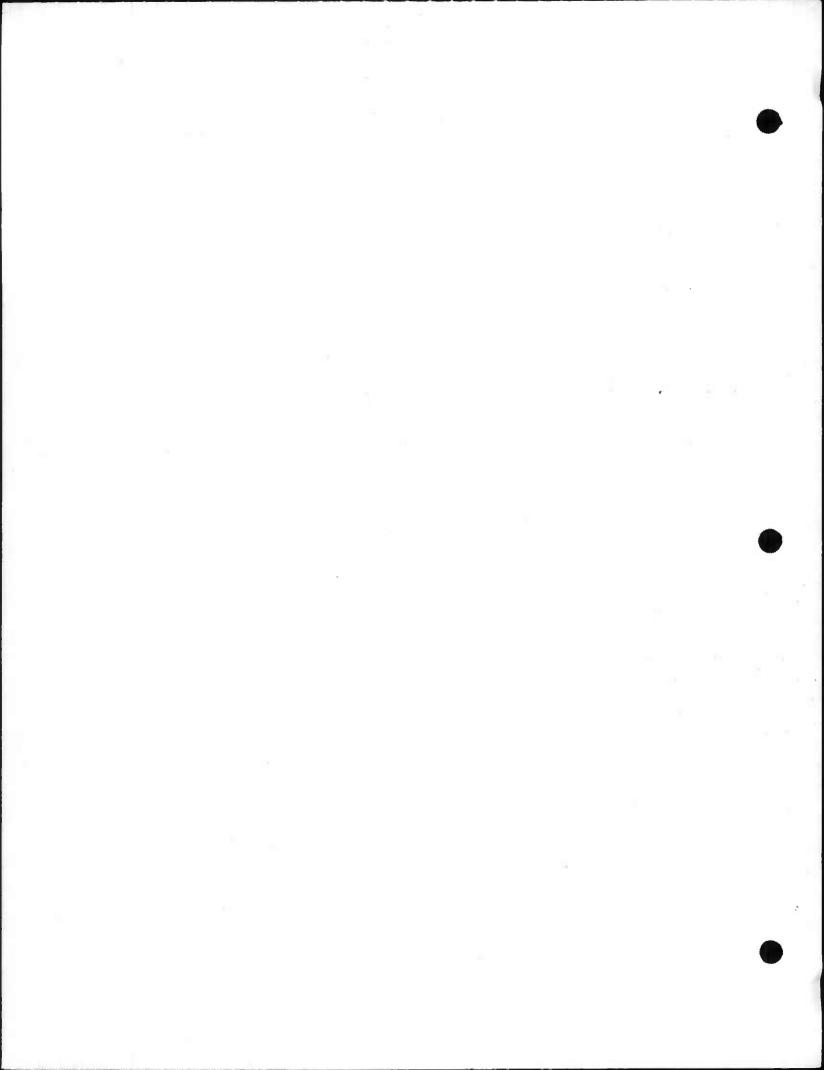
1 - FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last)

WALTER

4. SOCIAL SECURITY NUMBER

		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE O	F BIRTH Day, Year)		8. BIRTHPLACE (State or Fo. Country)	reign
P		327-26-1403	1XXM 2 🗆 F	61	YRS.				June	9, 19	33	Illinois	
3 should	Œ	9a. FACILITY NAME (If not institution, give		ODTE AT	19	9b. CITY, TOWN						TY OF DEATN	
1, 2, 3	CTO	THE JOHNS HO	OPKINS HO	SPITAL		BAL	TIMOR	E CI	TY		Nor	ne	
Pages	- п ш	10a. STATE 10b. COUNT	Υ		10c. CITY,	TOWN OR LOC	ATION					10d. INSIDE CITY	
# <u>.</u>	DIR	Pennsylvania Fult	on		War	fordsb	Jrg					1 TYES 2 X	NO
permit.	l ₹	10e. STREET AND NUMBER				1	of. ZIP CODE	ZIP CODE 10g. CITIZEN OF WHAT COUNTRY					
an. Tansit	FUNERAL	Route 1, Box 765					1726				nited States	1	
020 physician. bunal-transit	5	11. MARITAL STATUS 1 Never Married 2 X Married	FORCES?	NT EYER IN U.S. AF	S 2 NO II yes, specify Cuban, Mexican, Puerto Rican, atc.) B							14. RACE — American Indie Black, White, alc.	n,
O 2 2	₽	3 Widowed 4 Divorced	Korea	MAR OR DATES	The second							Specify: White	
attendi		15. DECEDENT'S EDU (Specify only highest grade	CATION	16a, DE	CEDENT'S U	SUAL OCCUPAT	ION		16b. I	(IND OF BUS	INESS/INDU		
\$ 0 P	Ē	Elementary/Secondary (0-12)	College (1-4 or 5	life	(Give kind of work done during most of working life. Do NOT use retired.)								
AND 2 he hospital detached for	COMPL		6	Fai	rmer /	Write	r Farming / Journal:					ournalism	
de the	= -	17. FATHER'S NAME (First, Middle, Last)			18. MOTNER'S NAME (First, Middle, Maiden Surname)								
		Harold Sinclair 190. INFORMANT'S NAME (Type/Print)		1 10	Ethel Moran 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
MAR retained 5 should	TO B	Christine A. Pet	erson	19		as 10	and Number	or Hural H	loute Number	r, City or Towi	, State, Zip	Code)	
	2	20a. METHOD OF DISPOSITION		20b. PLACE	ANDDATEOF	DISPOSITION //	Name of		OATE	20c, LO	CATION — C	ity or Town, State	
e e o	IS NE	1 Donation 5 Other (Specify)	oval from State	Chesa	Thetery, cremetory or other place) Thesapeake Crematory 2–24 Beltsville, Mar								d
TIN Pag ral di	схашивс	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	0		22. NAME	AND ADDRES		HLITY				
BALTI after death. P by the funeral moval.	EXSIL	I Cleen	W. /	app		Rapp						ng, MD 20910	1
S after by the emoval.		23. PART i. Enter the diseeses, or	complications the	et coused the de	eth. Do no	t enter the m	ode of dyli	ng, such	es cerdia	c or respi	ratory erre	st, Approxima	
hours led in b	E	ehock, or heert feliure. IMMEDIATE CAUSE (Finei	Liet only Dne cer	use Dn eech line	9.							interval Be Onset and	
nin 24 tely fi mation	-	disease or condition resulting in deeth) a. Hemorrhole											
ted within completely ial, cremat	CVEIII,		OUE TO	IOR AS A CONSE	OUENCE OF):	+		-					1/
executed and corr	NO NO	Sequentially liet conditions,	b	IOR AS A CONSE	Infa	rclia						100	ell
or day	CATION	if any, leeding to immediate ceuse. Enter UNDERLYING	/10	MODA +	LO SENSE	Pan	Parcretic Alexacoraneme						21
certificate ding physical tygiene pri	RTIFIC	CAUSE (Diseese or injury thet initiated events	DUE TO	DUE TO JOR AS A CONSEQUENCE OF):						Q- STREME			
The certification of the certi		resulting in death) LAST	d	er forati	death but not resulting in the underlying ceuse given in Part I. 24a. WAS A							1-30	lax
the death the atten d Memtal H	L CE	PART ii. Other significent condition	ns contributing to	death but not i							AUTOPSY	24b. WERE AUTOPSY FIR	9
that the ed by	MEDICAL					tive arrange	ng occor g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFOR	MEO?	AVAILABLE PRIOR T	то
requires een signe of Healtl						-			- 1	YES 2	□ NO	DF DEATH?	
- 9 -	- Z	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YES	□ NO [J UNC	ERTAIN				1 TYES 2 N	U
- 20	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				(Check only one							
	YSI	1 X YES 2 - NO	HOSPITAL: 1 Inpatient 2	ER/Outpetlant 3		OTHER:	ma 5 🗆 Red	eldenca 8	B 🗆 Other (Specify)			
ATTENDING PHYSICIAN: ECTOR: After this certific s after death with the Si		27. MANNER OF DEATH	28a. DATE OF (Month, D	INJURY Day, Year)	28b. TIME		JURY AT ORK?		28d. DEŞC	RIBE NOW IN	JURY OCC	JRED	
After the death v	BY PH	1 Natural 5 Pending 2 Accident Investigation					YES 2	NO NO					
TTENDI TOR: A after d		3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE C building,	OF INJURY — At ho atc. (Specify)	ma, farm, str	eel, factory, offi	ca		281. LOCAT City or	TON (Street a Town, State)	nd Number o	or Rural Route Number,	
- E E 5	COMPLETED	29a. CERTIFIER											
로 글 전 :	M M	(Check only 1 LX CERTIFYING PHYS											
TO THE HOSPI TO THE FUNER be filed within	8			xamination end/or	investigation,	in my opinion,				nd place, end	f due to the	ceuse[a) and mennar as st	ited.
물 물 물 물	E H	296. SIGNATURE AND TITLE OF CERTIFIE	1 00	α Λ				NSE NUMI			29d. DATE	SIGNED (Month, Day, Year)	
223	2	30. NAME AND ADDRESS OF PERSON WH		M ().	M 27) /7/me P	rint)	PCH	147.				स्रपाद ५	
		Gov N. Wolf	he I -	John		skin	Hosp	tel	Sas	Chmo	re 1	D 21287	
		31. DATE FILED (Month, Day, Year)	le .	R'S SIGNATURE			1					(
		MAR 02 1995	Alia dave	lear Randal	4								
		1000	4										



OHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

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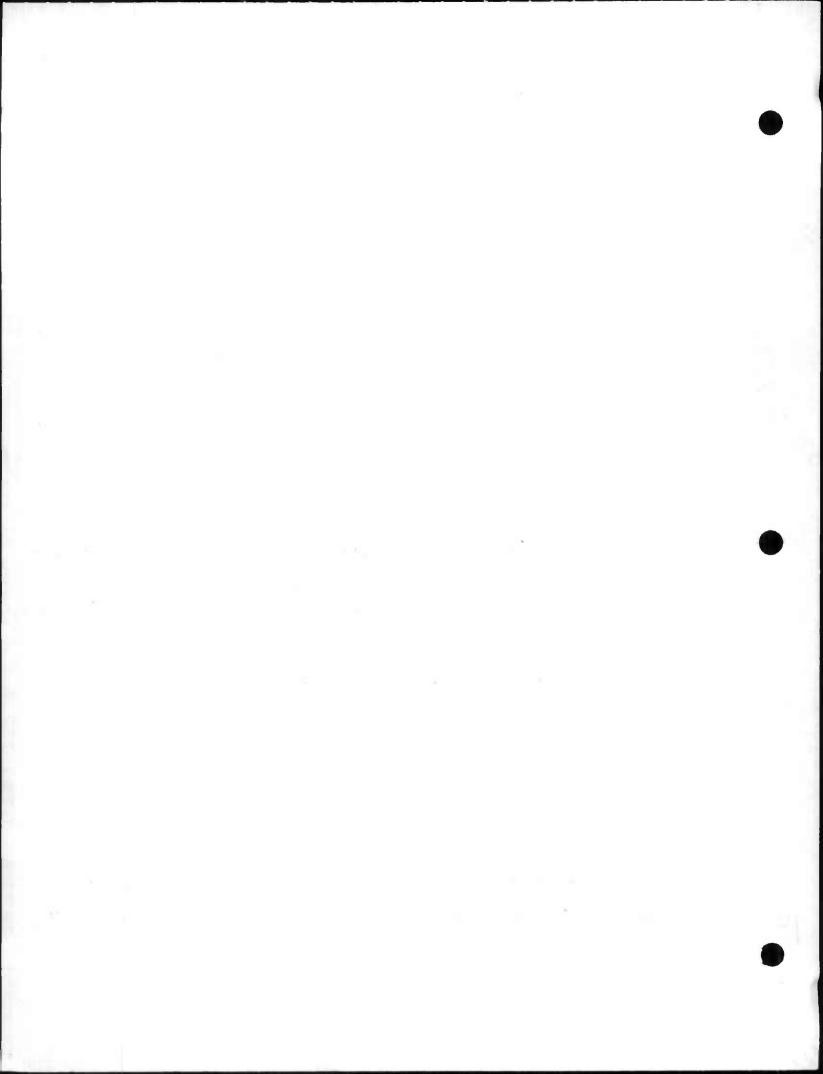
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

-	HEGISTHAN			EKIIF	ICALE	OF	DEAL	H	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	CTD	CCTCC						2. DATE OF MONTH	DEATH	lv .	YEAR	3. TIME OF OEATH
	EDWARD		EETER						EBRUA	RY 2	7. 1	995	12:40 A
			. AGE (In yrs. las	si birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER 2	24 HRS.	7. DATE OF I	BIRTH ly, Year)		8. BIRTH Countr	IPLACE (State or Foreign
		1 XM 2 F	B3		March				4, 1911 Arkansas			kansas	
nc	9a. FACILITY NAME (If not institution, give stre				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE							EATH	
2	Prince George's Ho	ospital (enter		Cł	Cheverly						nce	George's
E	10a. STATE 10b. COUNTY			10c. CITY	Y, TOWN OF	LOCAT	ION				10d. INSIDE CITY		
F -	Maryland Prince	e George'	S		anito	n] H	leigh	ts					LIMITS?
AL.	10e. STREET AND NUMBER			101. ZIP CODE							10g. CIT	IZEN OF W	WHAT COUNTRY?
ER	5024 Addison Road				20743						States		
FUNERAL DIRECTOR		RMED	13, W	AS DEC	ENOENT OF	HISPANIC	C ORIGIN? (S	pecify Yes		_	— American Indian,		
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	NO					Puerto Ricar	n, atc.)		Speci			
												81	ack
15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSI										INESS/INI	DUSTRY		
15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) B 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fuel Systems Operator 16. KIND OF BUSINESS/INDUSTRY Dept. of Air Force 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)													
M	17. FATHER'S NAME (First, Middle, Last)		True	I Sys	tems	Upe			Uep¹ € (First, Middi			For	ce
	Lloyd Streeter								м. Вз		Sumame)		
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a			oute Number, (Ctote 76	o Codel	
2	Dorothy Ann Phil	lins			as .			or That to	uto reambor, c	aty or low	r, State, 2.g	o Code)	
	20s. METHOD OF DISPOSITION		20b. PLACE	AND DATE O	OF DISPOSIT	_	me of		DATE	20c. LO	CATION —	City or To	wn. Stata
	1 X Burial 2 Cremation 3 Remov 4 Donation 8 Other (Specify)	al from State	Fort.	matory or of	her place)	Ceme	terv		3-3				aryland
1	21. SIGNATURE OF FUNERAL SERVICE LICEI	ISEE	1		22. N	AME AN	D ADDRES	S OF FACE	LITY				di y idila
	Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910												
	23. PART I. Enter the diseases, or con	mplications that o	eused the de	ath. Do n	ot enter t	be mov	te of dvin	venu	e, Si.	Lver	Spri	.ng,	
- 1	anock, or neert tallure. Li	st only one ceuee	on each line				ao or ayını	y, accii	aa cerdiec	or reapi	atory ar	rest,	Approximata interval Between
	iMMEDIATE CAUSE (Fine) disease or condition	C 0	· 0.	1									Onset and Death
	resulting in death) e.	DUE TO (O	R AS A CONSE	DUENCE OF	Megre	4							10 minutes
z		Ischan	ue C	D.	~	-1	۲.						loyeas
일	Sequentially list conditions, if any, leading to immediate	DUE TO (O	R AS A CONSE	DUENCE OF	- d	0-1	7						
S	CAUSE (Disease or injury	Com	y les	don	1 6)u	ane						25 years
	that initiated events resulting in death) LAST	DUE TO (O	R ASIA CONSE	DUENCE OF	i i								
CERTIFICATION	d.												
	PART II. Other aignificent conditions	contributing to de	eth but not r	eeulting is	n the und	erlying	ceuse gi	ven in Pa	art i. 24e	. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL	- Anulin Re	reder	Drob	exe	· M	ا مو	de la	8	1,0	PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
		2							_ ''	YES 2	X		OF DEATH?
ż	DID TOBACCO USE CONTRI	BUTE TO CAU	SE OF DEA	TH YE	S 🗆 N	0 🗆	UNCE	RTAIN	X				1 TES STANO
SIA	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT									
Š	A Clause Action	IOSPITAL:	R/Outpatient 3	□ DOA	OTHER:		5 Resi	idence 8	☐ Other (Sp	ecify)			
PHYSICIAN: M	27. MANNER OF DEATH 1 Netural 5 Pending	20a. DATE OF IN (Month, Day,		28b. TIME	OF 2	8c. INJL		2	20d. DESCRIE	BE HOW IN	JURY OC	CURED	
B	1 Natural 5 Pending 2 Accident Investigation				M	1 🗌 Y	ES 2 [ND					
<u>n</u>	3 Suicide e Could not be determined	28s. PLACE OF I building, ato	NJURY — Al ho . (Specify)	me, farm, a	treet, factor	y, offica		2	City or To	N (Street ar	nd Number	or Rural R	oute Number,
E.													
린	29a. CERTIFIER (Check only one)	N: To the best of my	knowledge, de	ath occurre	d at the tim	e, date :	and place, a	and due to	the cause(s	and man	ner sa atai	ed.	
COMPLET	000) 2 MEDICAL EXAMINER:	On the basis of axan	ination and/or i	investigation	n, in my opi	nion, de	ath occured	d at the tir	me, data and	placa, and	due to th	e cause(a)	and menner as stated.
BE	296, SIGNATURE AND TITLE OF CERTIFIER						29c. LICEN	ISE NUMB	ER		29d. DAT	SIGNED	(Month, Day, Year)
2	(Dear)	and					D 1	6410			▶ 2	27	95
-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITE				,		27.		0	1	11.
	COABLIE JA	HPFE (とう・	7	500	> 6	ocent	UOR	Plu	1	4	reenl	oet hus
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	_							1	-		
	MAR 02 1005	Valia Days	sor Rond	11.									



BALTIMORE, MARYLAND 21215-0020	Jing physician.
1215	or attending
ND 2	by the hospital
YLA	by the
MAR	retained
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BAL	ter death
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Pages 1, 2, 3 should

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use as the burial-transit

funeral director, page 5 should be detached for

completely filled in by the rial, cremation, or removal.

MAR 02 190

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cremation, or

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۵	DIVISION OF VITAL RECORDS, P.O. BOX 68760	ONC	FVI	AL	REC	ORD	D, D	O. B	9 XO	8760	Ö
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	DR ATTEND	IING PHYS	ICIAN:	The law	requires	that the	death	certificate	pe exe	cuted wi	量
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely	DIRECTOR: /	After this o	certificat	e has	peen sign	ed by the	afteno	ling phys	ician an	р сотр	etely
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crematic	ours after c	death with	the Sta	te Dept	of Heal	th and M	ental H	ygiene p	rior to b	unial, cre	matic
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, it	lem 28 is	marked	, or ite	m 23	shows	any inju	Iry, or	other	папта	lic ever	Ħ,#

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH GERTRUDE FEB 11 05 AM .. SMITH 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign July2, . Virginia 1 - M 2 - F 80 YRS. 214-30-2270 1914 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda MONTGOMERY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Rockville Maryland Montgomery 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4301 Muncaster Mill Road 20853 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO Specify: BY 3 Midowed 4 Divorced Specify: Black 15. DECEDENT'S EDUCATION COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi ntary/Secondary (0-12) 12th College (1-4 or 5+) Housewife None once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surnam Benjamin McKenney Catherine Cully F BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code).
4301 Muncaster Mill Rd., Rockville, MD 20853 2 Larry McKenney (Grandson) pe 20a. METHOD OF DISPOSITION
1 ②Burlel 2 □ Cremation 3 □ 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Gate Of Heaven Cem. Silver Spring, MD 3/4 4 Donatlog B Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENSEE examiner SNOWDEN FUNERAL HOME, P.A. 12 ROCKVILLE, MD 20850 23. PART I. Enter the diseases, or compileations that caused the death. Do not anter the mode of dying, such as cardiec or respiratory errest, shock, or hast failure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition PANCREATIC METASTATIC CARCINOHA WITH event, reaulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): traumatic GATRIC CERTIFICATION OUTLET OBSTRUCTION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? any 1 TYES 2 T NO shows a 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL:
1 Department 2 ER/Outpetlant 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED S Could not be 4 Homicide 29a. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the heat of aramination and/or impediation in The State of the Cause(a) and menner as stated. 2 - MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) MI Magaza muan D-27660 2/27/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MD 20910. ALPANA GOSWAN I SIWER SPRING

ROAD

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32. REGISTRAR'S SIGNATURE

in Davilson Revolally

3. TIME OF DEATH

FOR

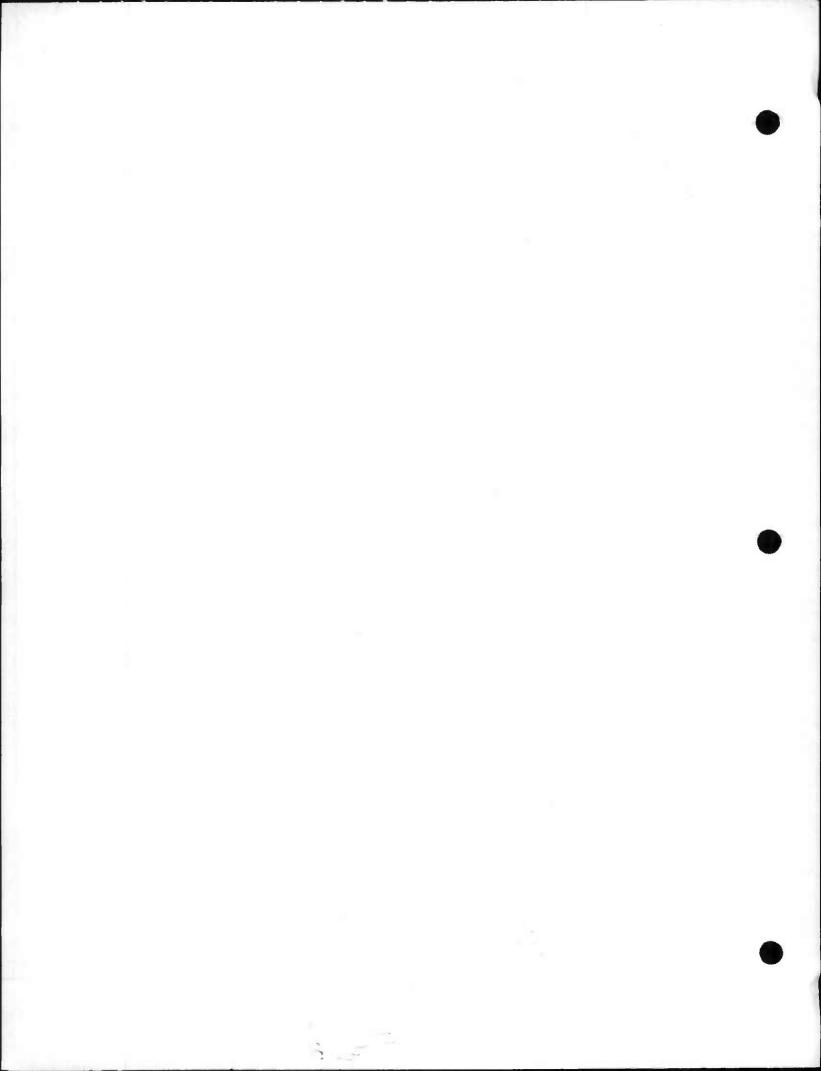
REGISTRAR

1. DECEOENT'S NAME (First, Middle, Last)

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2. DATE OF DEATH MONTH Natalie E. Smith 5:15 February 28,1995 PM 4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 79 HOURS 164-03-9587 1 M 2 X 1 YRS. May 21, 1915 Pennsylvania permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 14800 Lindsey Lane Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 14800 Lindsey Lane 20906 use as the burial-transit United States retained by the hospital or attending physician. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried 1 YES 2 NO Specify: BY 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION secify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe be detached for College (1-4 or 5+) 12 Secretary Insurance/Bank once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) 7 Charles Ehrenstrom Louise MacKinnon BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Joan A. Hamilton 212 N.Heron Drive #3, Ocean City, Maryland 21842 90 9 20e. METHOD OF DISPOSITION
1 □ Burlel 2 ☑ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of commetery, crematory or other place) March 2, 1995 Montgomery Crematorium, Inc. Раде 6 тау OATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Bethesda, Maryland 22. NAME AND ADDRESS OF FACILITY
ROBERT A. Pumphrey Funeral Home/Rockville,
300 West Montgomery Avenue
Rockville, Maryland 20850-2805 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE death. be executed within 24 hours after dealian and completely filled in by the fur it to burial, cremation, or removal. M00198 low medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or haart failure. List only one cause on each line. Interval Batwean IMMEDIATE CAUSE (Final Onset and Death the disesse or condition Respiratory Failure 24 hours event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 2 days Pneumonia traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician Mental Hygiene prior to death certificate be cause. Enter UNDERLYING Metastatic Cancer of Breast 3 years CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST Cancer of the Breast 0 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? pt. of Health and N any Confusion, Cognitive Dysfunction 1 - YES 2 0 NO requires OF DEATH? Shows Osteoarthritis, Anemia, Gastric Ulcer 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IN UNCERTAIN I PHYSICIAN: has be Dept. WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The this certificate h HOSPITAL OTHER: 1 X YES 2 - NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 🔀 Residence 8 🗌 Other (Specify) 10 27. MANNER OF OEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending DIRECTOR: After the hours after death v BY 1 YES 2 NO Investigation 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide .00 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homictée 500 Hem 29s. CERTIFIER
1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL C within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE (auless his D25410 March 1, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Oliver J. Lawless, M.D. 3801 International Drive, Silver Spring, MD 10 32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) 03 1995 DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

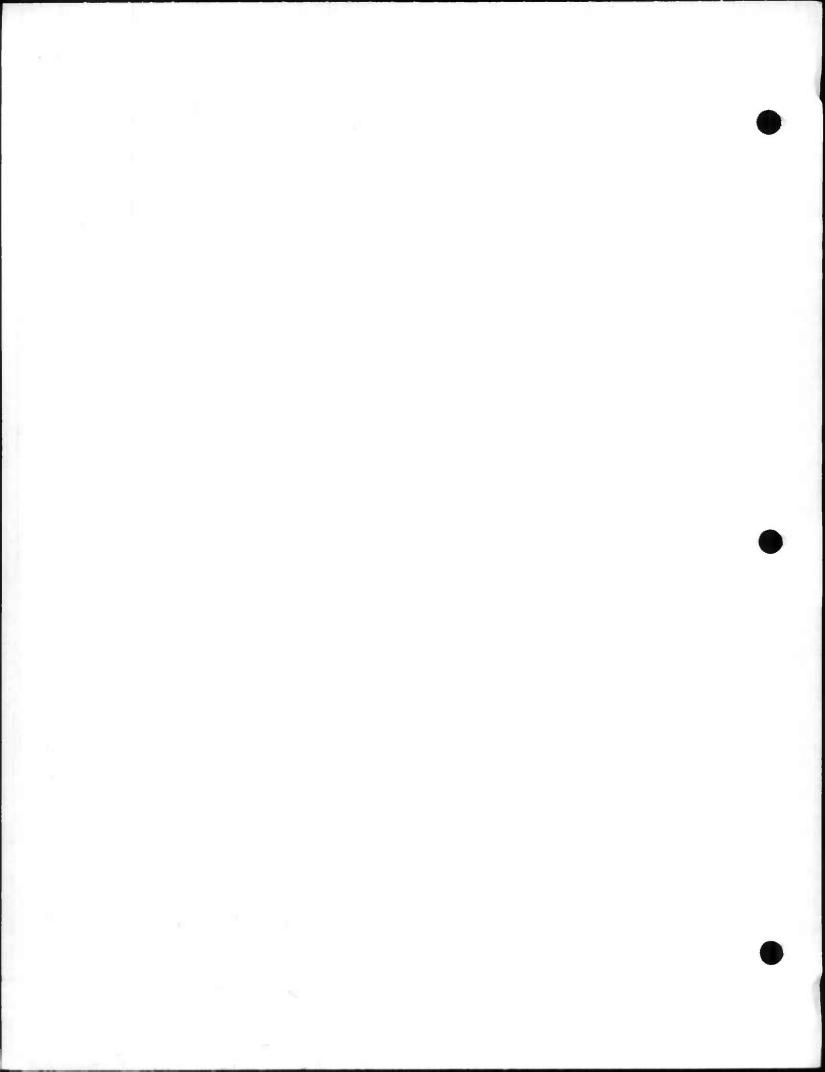
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH
	Sigfus Orn				Ci	Sigfusson				MONTH DAY YEAR				
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.				Feb 27 1995			0307 M			
	228-19-6114		1 📉 M 2 🗆 F	63	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mont	th, Day, Year)	22	Countr	γ)
	9s. FACILITY NAME (If not in		treet and number)			96, CITY	. TOWN (OR LOCATI	ON OF DE		5, 19		NTY OF D	Iceland
۳ ا	Charle Wes		a .				Raltimore None						Carr	
5	Shock Tr					L Ba	Iti	more				NOU	e	
DIRECTOR	10a. STATE	10b. COUNTY	Y		10c. CI	TY, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
	Maryland	Mon	tgomery		No	rth	Beth	esda						1 TES 2 1 NO
FUNERAL	10e. STREET AND NUMBER						101	ZIP CODE	E			10g. CIT	ZEN OF Y	VHAT COUNTRY?
Ä	10931 Blo	omingd						0852					1and	
5	11. MARITAL STATUS 1 Never Married 2 X	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED NO	13.	WAS DEC	ENDENT C	OF HISPAN	VIC ORIGI	N? (Specify Yes Rican, atc.)	or No-	14. RACE Black	- American Indian, c, White, stc.
BY	3 Widowed 4 Divo		IF YES, GIVE W	AR OR DATES				2 🛚 NO			,		Speci	fy:
	15. DEC	EDENT'S EDU	CATION	16e. I	ECEDENT'S	I IISHAL O	CCUPATIO	DM .		140	. KIND OF BUS	1		White
COMPLETED	(Specify onl	y highest grade	completed) College (1-4 or 5 4		Give kind of fe. Do NOT u	work done	during ma	st of working	יס	100	KIND OF BUS	HNESS/INL	JUSTRY	
P					ivil Engineer					World	Bank			
Š	17. FATHER'S NAME (First, Middle, Last)						-	18, MOTI	HER'S NA		Middle, Maiden			
BE C	Sigfus Kristiansson					Elin Gudbjartsdo						tir		
					9b. MAILING	AILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2085.						20052		
2	Margret J. Sigfusson				10931 Bloomingdale Drive, N. Bethesda, Maryland									
	20s. METHOD OF DISPOSITION 20b. PI				ACE AND DATE OF DISPOSITION (Name of 3 / 15 / 95 DATE 20c. LOCATION — City or Town, State y, crematory or other place)							wn, State		
- 1	4 Donation 6 Other (Specify) Kirki										Reyl	cjavi	k, I	celand
- 1	21. BIGNATURE OF FUNITAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY RODE T. A. Pumphrey Funeral Home / Ro								Pothorda					
	Micha	14	Augu	ls N	100846	5 Ch	evy	Chas	e, I	inc.	7557	Wisc	onsi	n Avenue
	23. PART i. Enter the di	iseases, or o	complication) that	caused the	leath. Do	not enter	the mo	da of dvi	no. auch	h as car	diac or reapi	ratory an	rest	Approximate
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.											interval Between Onset and Death		
	iMMEDIATE CAUSE (Final disease or condition					. B.								Oriset and Death
	disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):													
z														
음 I	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
< II	CAUSE (Disease or injury													
2	CHOSE (Disease of Iulin		c											
TIFIC	that initiated events	7	DUE TO	(OR AS A CONS	EOUENCE O	F):								
CERTIFIC		7	DUE TO	(OR AS A CONS	EOUENCE O	F):								
AL CERTIFIC	that initiated events	T	d,				deriying) cause g	ilven in	Part i.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
SICAL CERTIFIC	that initiated events resulting in death) LAS	ry T	d,				nderiying) cause (ilven in l	Part i.	PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
AEDICAL CERTIFIC	that initiated events resulting in death) LAS	ry T	d,				nderiying) cause g	given in i	Part I.		MED?	24b.	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N: MEDICAL CERTIFICATION	that initiated events resulting in death) LAS PART ii. Other aignifica	nt condition	s contributing to	death but not	reaulting	in the un				_	PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
1	that initiated events resulting in death) LAS PART ii. Other aignifica DID TOBACCO U 25. WAS CASE REFERRED TO	nt condition	s contributing to	death but not	reaulting	in the un	NO 12		ertain	_	PERFOR	MED?	24b.	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1	that initiated events resulting in death) LAS PART II. Other aignifica DID TOBACCO U	nt condition	s contributing to	USE OF DE	reaulting ATH YI	in the un	NO (A		ERTAIN	N 🗆	PERFORI	MED?	24b.	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1	PART II. Other aignifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 2 YES 2 NO 27. MANNER OF DEATH	nt condition SE CONTI	s contributing to RIBUTE TO CA HOSPITAL: 1 Inpetient 2	USE OF DE. 26. PL. XER/Outpatient	ATH YINCE OF DEA	in the un TH (Check OTHEF 4 Nun	only one) T: sing Hom	UNC	ERTAIN	S Othe	PERFORI	MED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN:	That initiated events resulting in death) LAS PART II. Other aignifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5	nt condition	S contributing to RIBUTE TO CA HOSPITAL: 1 □ Inpatient 2 2	USE OF DE. 26. PL. XER/Outpatient	ATH YINCE OF DEA	in the un	only one) T: sing Hom 28c, INJ	UNC	ERTAIN	8 Othe	PERFORI	MED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
D BY PHYSICIAN:	DID TOBACCO U S. WAS CASE REFERRED TO EXAMINER? 1 Netural 5 Netural 2 Accident 3 Suicide 6	nt condition SE CONTR D MEDICAL Pending investigation Could not be	RIBUTE TO CA HOSPITAL: 1 Inpatient 2 28a. DATE (Month, D. 20), 26e. PLACE (Ol. 28e. PLACE OL. 28e. PLACE (Ol. 28e. PLAC	USE OF DE. 26. PLI EN/Outpatient INJURY — At tet, (Specify)	reaulting ATH YI ACE OF DEA 3 □ DOA 28b. TIME IN. Z.Z.S. oome, ferm,	in the un ES	NO (A) it: sling Hom WO 1 1	UNC 5 Re URY AT RK? (ES 2	ERTAIN	8 Otho 28d. DES 28f. LOC	PERFORI 1 XYES 2 If (Specify) GCRIBE HOW IN TO CAL ATION (Street a)	IJURY OCC	CURED 7	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 104 YES 2 NO
ED BY PHYSICIAN:	DID TOBACCO U S. WAS CASE REFERRED TO EXAMINER? 1 Netural 5 Netural 2 Accident 3 Suicide 6	nt condition SE CONTR D MEDICAL Pending investigation	RIBUTE TO CA HOSPITAL: 1 Inpatient 2 28a. DATE (Month, D. 20), 26e. PLACE (Ol. 28e. PLACE OL. 28e. PLACE (Ol. 28e. PLAC	USE OF DE. 26. PLI EN/Outpatient INJURY — At tet, (Specify)	reaulting ATH YI CCE OF DEA 3 □ DOA 28b. TIN. 2.2.5	in the un ES	NO (A) it: sling Hom WO 1 1	UNC 5 Re URY AT RK? (ES 2	ERTAIN	8 Other	PERFORI 1 XYES 2 If (Specify) GCRIBE HOW IN TO CAL ATION (Street a)	MED? NO NO JURY OCC MUL A Number I 9 5	CURED 7	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 104 YES 2 NO
ED BY PHYSICIAN:	That initiated events resulting in death) LAS PART II. Other aignifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only) 1 CERT	nt condition SE CONTI D MEDICAL Pending investigation could not be determined	RIBUTE TO CA HOSPITAL: 1 Inpatient 2 28a. DATE Of (Month, Duliding,	USE OF DE. 26. PL/ XER/Outpettent INJURY F INJURY — At hatc. (Specify)	ATH YI CCE OF DEA 3 DOA 28b. TIM 225. in. 275.	in the un TH (Check OTHEF 4 Num BE OF WINTY M street, tact	NO (2) conly one) T: slng Hom 28c. INJI WO 1 Y ory, office	UNC 5 Re URY AT RK? (ES 2	ERTAIN sidence	8 Other 28d. DES Mo 28f. LOC City But	PERFORI 1 XYES 2 Fr (Specify) SCRIBE HOW IN TO CAL ATION (Street are or Town, State)	MED? NO NO NO NURY OCCUPANT A STATE OF STAT	CURED OF RURAL R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 104 YES 2 NO
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ED BY PHYSICIAN:	that initiated events resulting in death) LAS PART II. Other aignifica DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only one) 2 2 2 2 3 3 4 4 4 4 4 5 6 7 7 7 8 7 8 7 8 7 8 7 8 7 8 8	T CONTINUE C	BRIBUTE TO CA HOSPITAL: Inputent 2 28a. DATE OF (Month, Did Duilding.) CIAN: To the best of except the part of the best of the part of	USE OF DE. 26. PLI ER/Outpatient INJURY — At hetr. (Specify) The str. (Specify) The str. (Specify) The str. (Specify) The str. (Specify) The str. (Specify) The str. (Specify)	ATH YI ACE OF DEA 3 DOA 28b. TIM N. 225. Ome, farm, The Leath occurr Investigation	in the un TH (Check OTHEF 4 Nun EL OF JURY M street, tact and at the ti on, in my o	only one) 1: sing Hom 28c, INJI WO 1	UNC 5 Re URY AT RK? ES 2	ERTAIN sidence NO and dus and dus ed at the times num	5 Other 28d. DES 28f. LOC City But to the cautime, data	PERFORI 1 XYES 2 If (Specify) SCRIBE HOW IN ATION (Street a or Town, State)	JURY OCCUPANT OCCUPAN	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 104 YES 2 NO LUCLEUT OUTS Number: 295 and manner as stated.
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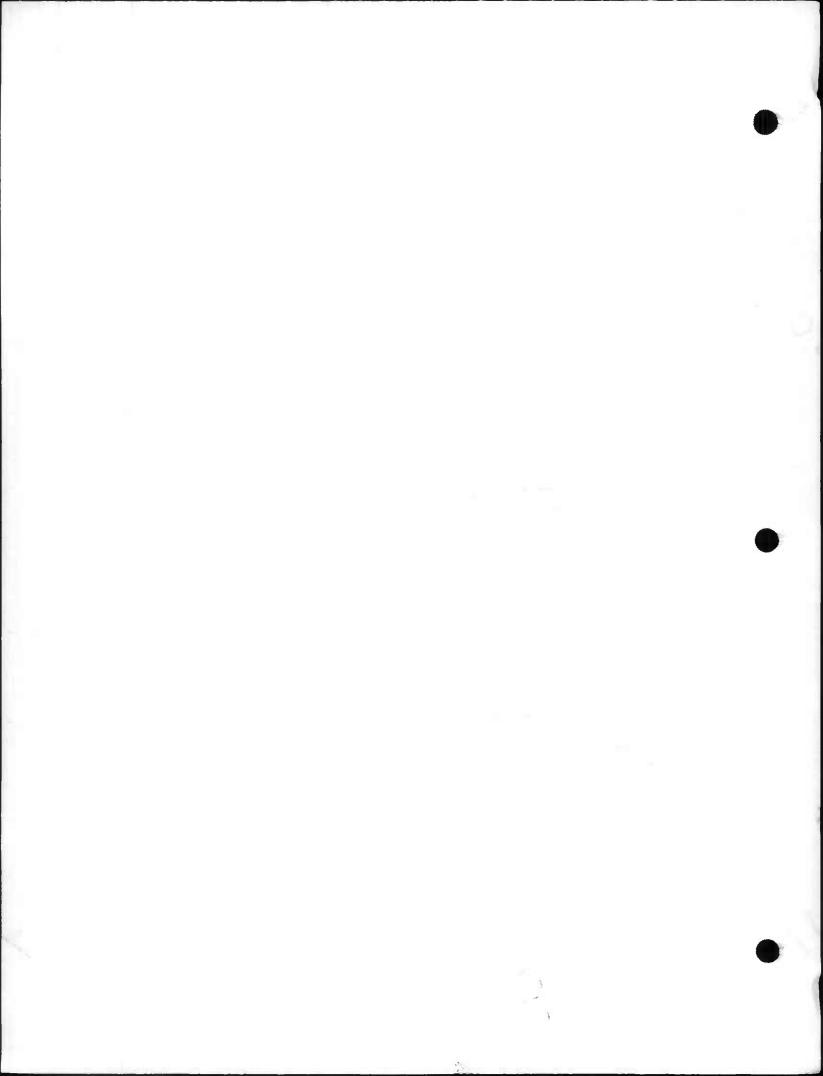
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and local part of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

	REGISTRAR		CI	ERTIF	ICAT	E OF	DEATH		REG. NO	_			
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR									3. TIME OF DEA	\TH			
	Paul LaForce Sulliva						February			**		3:55	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDE	R 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		e. BIRTH	IPLACE (State or I	
	229-20-9269	1 🔀 M 2 🗌 F	69	YRS.	MONTHS	DAYS	HOURS MIN.	Till	n, Day, Year)	1925	Mas	m sachuse	tts
1	9e. FACILITY NAME (If not institution, give a					Y. TOWN C	R LOCATION OF D		1	7	NTY OF D		000
r l	Brooke Grove Nursing Home												
	RESIDENCE OF DECEDENT					Olney Montgomery							
ŭ	10e. STATE 10b. COUNT	Y		10c. CIT	, TOWN OR LOCATION							10d. INSIDE CIT	Υ
DIRECTOR	Maryland Mo	ntgomery			Beth	esda	L					LIMITS?	ON S
ال	10e. STREET AND NUMBER					10f	ZIP CODE			10g. CIT	IZEN OF V	WHAT COUNTRY?	
	7513 Ben Avon Ro	ad					20817			Ur	ited	States	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AF	RMED	13.	WAS DEC	ENDENT OF HISPA	NIC ORIGIN	2 (Specify Ver			E American Inc	
	1 Never Merried 2 Married	FORCES? 1 F	YES 2 1	NO		If yes, spe	cify Cuben, Mexic	an, Puarto F	Rican, etc.)	0.110	Blaci	k, White, atc.	11417,
BY	3 Widowed 4 Divorced	1	II			I 📋 TES	2 NO Speci	ny:			Spec	White	
3	15. DECEDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL C	CCUPATIO	N .	16b.	KIND OF BU	SINESS/IN	DUSTRY		
	(Specify only highest grade Elementary/Secondary (0-12)	(G	(Give kind of work done during most of working life. Do NOT use retired.)							Data			
COMPL	College (1-4 or 5 +)				lf Employed				rafts	nan/F	Pate		
5	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S N.						
	Chester Paul LaF	orce					Mary G			.,	1		
H H	19e. INFORMANT'S NAME (Type/Print)		10	h. MAH ING	ADORES	S (Street e	nd Number or Rural	Ocusto Alumi	or Chros Tou	n Chata 7	n Codel		
2	Karen Marie Drosd	zal					ntal Ct					20832	
- 1	20a. METHOD OF DISPOSITION												
- 1	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ram	oval from State	cemetery, cre	ematory or of	her plece,	Mai	Ch 3, 19	995	200.10		City or To		Land.
	20b. PLACE AND DATE OF DISPOSITION 1 © Burlet 2 Cremetton 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION VIEWE (1 3, 1995) 20b. PLACE AND DATE OF DISPOSITION VIEWE (1 3, 1995) 20c. LOCATION — City or Town, State Capreley, cremetary or piles place) Capreley, cremetary or piles place) Capreley, cremetary or piles place) Silver Spring, M 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22c. NAME AND APPRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/Rock												
- 1	.0.1.	1 ,	MOO	198	Ŕċ	bert	A. Pum	phrey	Funer	cal F	Iome/	Rockvil	le,
	Mary -	Jour	1100	150		300	west Mo.	ntqon	ery A	enue	-280		nc.
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, Approxim												
	shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition Cardio Vascular alla essertions)									Onset ar			
	disease or condition resulting in death)	car	duo V	ds	CUE	عالا	Colle	aps	E				
	resulting in deatily	DUE TO (OR AS A-CONSE	OUENCE OF	F):		1,1	V		Λ			
2	Acquired june vero Deticiency 5; udur e												
2	Sequentially list conditions, if any, leading to immediate DUE TO (OP AS A CONSEQUENCE OF):												
HILLCALION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury C. BUTTL LUSIUS IVSION 5												
=	that initiated events	DUE TO (A CONSEQUENCE OF): HEART SURGERT									
1	resulting in dasth) LAST	a OPEN	HOA	RT	SV,	1496	-R7						
5	PART II. Other significant condition	e contribution to a	leath hut not a	re eveletere d	- Ab - 41			pine I			al .		
MCAL	ADRTIC P	ROSTHES		raaulting i	in tha u	naeriying	cause given in	Part I.	24a. WAS AN PERFOR		246	WERE AUTOPSY I	OT P
5	10-110	1403	13					- 1	1 TYES 2	NO		COMPLETION OF OF DEATH?	CAUSE
Ĕ								,				1 YES 2	NO
Ž	DID TOBACCO USE C	ONTRIBUTE	TO CAUS	E OF	DEAT	TH Y	S NC	D					
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE		ACE OF DEATH (C	heck only on	o)				
ē	1 YES 2 NO	1 Inpetient 2	ER/Outpatient 3	□ DOA	4 Nu		e 5 🗆 Residence	8 🗆 Other	r (Specify)				
Ē	27. MANNER OF DEATH	28e. DATE OF II (Month, Day	NJURY (, Year)	28b. TIMI INJ	E OF URY	28c. INJ WO	URY AT RK?	28d. DES	CRIBE HOW I	NJURY OC	CURED		
5	1 Natural 5 Pending 2 Accident Investigation				М		ES 2 NO						
	3 Sulcide 8 Could not be	28e. PLACE OF building, e	INJURY At he tc. (Specify)	ome, farm, s	rtreet, fac	tory, office		28t. LOC	ATION (Street or Town, State)	and Numbe	r or Rural I	Route Number,	
MFLEIEU	4 Homicide datermined							, and	iven, state)				
ווי	29e. CERTIFIER (Check only 1 🔀 CERTIFYING PHYSI	CIAN: To the best of n	ny knowledge, de	ath occurre	d at the	time date	end place, and du	e to the cau	se(s) and me	nor so ele	ted	·	
2	(Check only one) 2 MEDICAL EXAMINE											a) and manner ee	stated
3	29b. SIGNATURE AND TITLE OF CERTIFIE												
	1 m li M	Luas	Mis)			29c. LICENSE NU			29d. DA	E SIGNED	(Month, Day, Year)
2	30 NAME AND ADDRESS OF DEDGG			****	0/ 1		-0 (01	V /			3/1	75	
	JOSEPH M Solina					702110	Cilvo	r Cna	ing 1	4 n m = - 7	224	20002	
	Jöseph M. Solina			-orgi	a AV	enue	, Silve:	r spr	riig, I	aryl	land	20902	
	31. DATE FILED (Month, Day, Year) MAR (13 1005 9	32. REGISTRAR	'S SIGNATURE										
19	MAK U. 1995	work or more											



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL DR ATTENDING PH	THE FUNERAL DIRECTOR: After thi	filed within 72 hours after death w	IPORTANT: If Item 28 Is mark
TO TH	TO TH	be filed	MPO

Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

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COMPL

BE

2

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

9

95 07999 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH DAY 1995 Joseph Smith March 2, 11:30 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 X M 2 - F 218-24-0884 AUG. 26,1928 66 MARYLAND 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ROUTE #425 Pisgah Charles RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND CHARLES PISGAH / INDIAN HEAD 1 YES 2XX NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? BOX #77 G ROUTE #425 20640 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 $\boxed{0}$ YES 2 $\boxed{0}$ NO IF YES, GIVE WAR OR DATES 1950 - 195211 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE - American Indian, Black, While, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 YES 2XXNO Specify: Specify: 3 Widowed 4 Divorced BLACK 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondery (0-12) College (1-4 or 5 +) ORDNAC MAN A&E TEST 9TH GRADE GOVERNMENT 17. FATNER'S NAME (First, Middle, Last) 18, MOTNER'S NAME (First, Middle, Meiden Surname) JOHN SMITH MARY HAWKINS SMITH 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HANNAH C. SMITH BOX #77G ROUTE #425 INDIAN HEAD, MARYLAND 20640 20a, METNOD OF DISPOSITION
1 № Burlel 2 □ Cremetion 3 □ Removal Irom State 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION — Cily or Town, State DATE ST. CHARLES CEMETERY 4 Donation 5 Other (Specify) 3/6/95 GLYMONT, MARYLAND 11 SIGNATURE OF PUNERAL SERVICE LICENSEE

LYDIA C. THORNTON JOHNSON MO0583 22. NAME AND ADDRESS OF FACILITY THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD.20640 23. PART I. Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellura. List only one cause on each line. intarval Between **IMMEDIATE CAUSE (Final** Onset and Death diseese or condition CANCER OF STOMACH NO resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events reculting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 T NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 YES 2- NO 4 ☐ Nursing Home 5 → Residence 8 ☐ Other (Specify, Inpetient 2 - ER/Outpetient 3 - DOA 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — Al home, lerm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as attend. 29e. CERTIFIER

> 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 9) D-28352

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 11340 Pembrooke Square, Suite Krishan Mathur. M.D. Waldorf, Maryland 20603

2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the lime, date end piece, and due to the cause(e) and manner as stated,

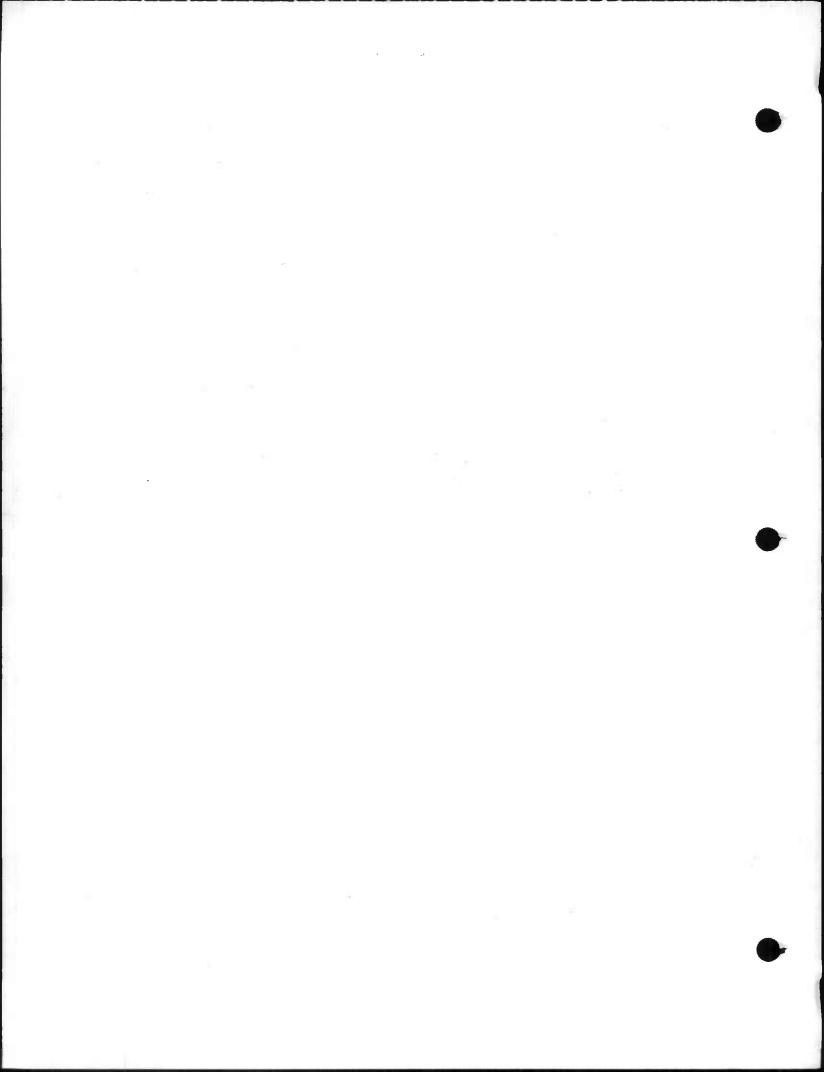
32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)

29b. SIGNATURE AND TITLE OF CERTIFIER

Kough

Davidson Rardall 1995

DHMH-18 Ray 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	REGISTRAR	CERTIF	CATE OF DEA	TH	REG. N	O.				
	1. DECEOENT'S NAME (First, Middle, Last)	<11.		2)	DATE OF DEATH	DAY / C	YEAR	TIME OF DEATH		
		Strider			Tarch 1	1/90	15	308N H		
	the state of the s	AGE (In yrs. last birthday)			DATE OF BIRTH (Month, Day, Year)	/ '	8. BIRTHPLA	ICE (State on Foreign		
	219 - 64 - 9389 1□ м 2 🕮 ғ	MONTHS DAYS HOURS		March 1	1,1933	Marvl	Land			
	9e. FACILITY NAME (If not institution, give etreet end number)	61 YRS.	96. CITY, TOWN OR LOCAT		-0.2 0		NTY OF DEATH			
E E	Laurel Regional Hospital		Laurel			Pri	nce Ge	orge		
Ĕ	RESIDENCE OF DECEDENT									
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									
	Maryland Anne Arundel	La	urel				11	LIMITS?		
A	100. STREET AND NUMBER	12.0	10f. ZIP COI	DE		10g. CITI	IZEN OF WHAT	COUNTRY?		
FUNERAL	241 Marganza S.	200	2072	4		USA				
3	11. MARITAL STATUS 12. WAS DECEDENT EV	ER IN U.S. ARMED	13. WAS DECENDENT		DIGIN2 (Specify)			American Indian,		
	1 Never Merried 2 Merried FORCES? 1 FYES, GIVE WAR (YES 2 NO	If yes, specify Cub	en, Mexican, Pu	verto Rican, etc.)	- Or NO	Black, Wh	hite, etc.		
BY	3 Widowed 4 Divorced	OR DATES	1 TYES 2 X NO	Specify:			Specify:	hite		
COMPLETED	15, DECEDENT'S EDUCATION	16a. DECEDENT'S	USUAL OCCUPATION		16b. KIND OF B	USINESS/IND		11200		
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of w	ork done during most of work a retired.)		00//11/00///11/0					
7	Grade 8	Homemak	er		Own Ho	nme				
8	17. FATHER'S NAME (First, Middle, Last)	110meman		THEO'S NAME (First, Middle, Maide					
	Clifford E. Bennett, Sr.			na G. I		n Sumame)				
H	19s. INFORMANT'S NAME (Type/Print)	405 MAILING	ADDRESS (Street end Number							
임	22 x 2 x 2 x 2 x 2 x 2 x 2 x 2 x 2 x 2									
- 1	Robert S. Strider, Sr.		arganza S.,							
	1 🖰 Burlel 2 🗆 Cremation 3 🗆 Removal from State	opmetery are matern	F DISPOSITION (Name of Cemetery		2/6		City or Town,			
	4 Donation 5 Other (Specify)	BOUGOIT FAI	22. NAME AND ADDRI		Ba	ltimor	ce, Mai	ryland		
	(11-11-11-11)		Donaldson			рλ				
	New It Jeger will							20707		
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate									
	snock, or-neart failure. List only one cause on each line.									
	IMMEDIATE CAUSE (Final Onset sn									
	disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):									
-	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
X	If any, leeding to immediate cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
F	resulting in deeth) LAST									
	d									
MEDICAL	PART II. Other significent conditions contributing to dear	th but not resulting in	the underlying cause	given in Part		N AUTOPSY ORMED?		RE AUTOPSY FINDINGS		
8					1 TYES		COM	MPLETION OF CAUSE DEATH?		
9								YES 2 NO		
ż	DID TOBACCO USE CONTRIBUTE TO CAUSE	E OF DEATH YE	S NO UNO	CERTAIN E	7			,		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
SIC	EXAMINER? 1 YES 2 NO 1 Inpetient 2 FR/		OTHER: 4 Nursing Home 5 R	neldenee e 🗆	Other (Perchi)					
主	27. MANNER OF DEATH 26e. DATE OF INJU	IRY 28b. TIME	OF 28c, INJURY AT		. DESCRIBE HOW	INJURY OCC	TURED			
	1 Netural 5 Pending (Month, Day, Ye	rar) INJU	IRY WORK?	NO	9200111011	moon occ	ONLO			
B	2 Accident Investigation 3 Suicide 6 Could not be 26e. PLACE OF INJ	URY — At home, farm, st			LOCATION (Steel	Lond Mumber		44		
	4 Homicide determined building, etc. ((Specify)	. ee, tactory, critica	201.	City or Town, Stat	e)	or nurei noute	Number,		
	29e. CERTIFIER									
를	(Check only 1 CEBRIFYING PHYSICIAN: To the best of my k									
COMPLETED	2 MEDICAL EXAMINER: On the basis of examin	sation and/or investigation	, In my opinion, death occu	ered at the time,	date and place, a	and due to the	e cause(e) end	manner ee stated.		
w II	296. SIGNATURE AND TITLE OF CERTIFIER		29¢. LIC	ENSE NUMBER		20d DATE	E SIGNEO (Mon	nth, Day, Year)		
8	Thegust & Koduse zm	D	12	1230		Vienes	42.1	995		
2	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	OEATH (ITEM 27) (Type,	Print)	/ 41	2 22		7/			
	HUBUSTOF. Kogrique 2/M	05009 K	ay but net	-Cp.S	M- 8h	1 20	748			
	31. DATE FILED (Agoth, Day, Year)	SIGNATURE	1	8 71		1				
	MAR 0 7 1995 Julia David	Gor Randall								
		- VV								

